The Katie A. Advisory Panel
Report to the Court
Annual Report for 2016
September 30, 2017

The Katie A. Advisory Panel
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EXECUTIVE SUMMARY

System Strengths and Accomplishments

In the 2016 monitoring period and more recently, the County has maintained progress in a number of key areas and also made progress in areas that have been continuing challenges. These are described below.

Growth in the number of Shared Core Practice Model (SCPM) Practitioners – The County reports that as of June 2017, DCFS has certified 2,209 SCPM Practitioners.

	SCPM PRACTITIONERS	SCPM COACHES	SCPM COACH DEVELOPERS	TOTAL	%
CSWs	1,494	20	3	1,517	58%
SCSWs	171	360	63	594	120%
OTHER (RA, ARA)	74	15	8	97	-
TOTAL	**1,739**	**395**	**74**	**2,208**	-

DCFS projects reaching 100% SCPM Practitioner certification of all CSWs by December 2018.

Development of System to Track the Use of Child and Family Team Meetings – DCFS has made progress in tracking the use of child and family team meetings, including tracking the frequency of subsequent meetings and the percentage of families and children who have experienced a team meeting in the past three months.

Reductions in DCFS Caseloads – DCFS, thanks to the Board's funding support, has been able to continuously lower caseloads. As of 2017, average caseloads are reported as follows.

Since January 2014, DCFS has added over 2,500 newly-hired Children's Social Workers, as a result of which, as of August 30, 2017:

1. The ***average*** Continuing Services caseload has reduced from 31.0 to ***20.3***; (target: 20 cases)
2. The ***average*** Emergency Response Caseload has reduced from 17.4 to ***13.7***; (target: 17 cases) and
3. The ***average*** Dependency Investigations caseload has reduced from 9.9 to ***8.8*** (target: 10 cases).

It is important to note that as significant as these reductions are, average caseloads do not fully describe the workloads of all DCFS staff. Some staff continue to practice with higher caseloads and a complete picture of workload would need data on the percent of staff with caseloads both lower and higher than the average and by what extent. There are also variances by DCFS offices.

Referrals to Medical Hubs – DCFS continues to refer a high percentage of newly-detained youth to medical Hubs for their Initial Medical examination. For 2016, DCFS referred 92% of newly detained children to a HUB, a higher percentage than the 89% performance in the prior year.

Expansion in Intensive Field Capable Clinical Services (IFCCS) - As of July 1 2016, DMH had expanded IFCCS providers from 5 to 21 and slots from 100 to 700, with further expansion planned.

***Expansion of DMH Supports for Immersion and the Qualitative Service Review (QSR)* –** While this development is more recent than the 2016 monitoring period, it does constitute an important step forward in implementing the settlement agreement. DMH is adding 58 new staff positions to assist in immersion, IFCCS and use of the QSR process, as the following update illustrates. This will bring the total number of positions dedicated to these functions to 74.

System Challenges

***Development of 300 Treatment Foster Care Beds* –** The County has made essentially no progress in implementing treatment Foster Care. As of December 2016, there were 79 certified homes and 72 children in these homes.

***Coaching DMH staff in the Shared Core Practice Model* –** While the recent ability of DMH to hire additional staff to assist in immersion implementation and other functions is encouraging, for the monitoring period, DMH did not have the resources to provide adequate support for immersion or SCMP implementation.

***Placement of Children in Close Proximity to their Come and Community* -** Currently and during the monitoring period DCFS had many children placed in non-kin settings outside of their office region. DCFS does not have enough family foster homes to serve children close to their families. This not only means children face more challenges in visiting their families, it also results in children leaving the schools they attended and caseworkers driving long distances to visit the children in their caseloads.

***Routine Use of Child and Family Teams* –** While DCFS has made significant progress in developing CFT facilitators and coaches, progress is modest in achieving the regular and ongoing use of CFTs with all families. Performance is somewhat higher in immersion sites than the non-immersion offices. High workloads remain a barrier to the frequent use of team meetings.

***Placement Disruptions* –** Placement disruptions continue to be a challenge for both DCFS and DMH. One of the purposes of IFCCS (intensive mental health services) was to prevent and reduce placement disruptions. During 2016 and in recent months with more focus, the parties and the Panel have discussed strategies for intensifying the response to placement instability, especially with mental health services. Currently, discussions are focused on the DMH capacity to respond immediately to threats to stability and with the appropriate intensity of services, matched to need.

***Overall Practice Performance – QSR Measures* –** DCFS and DMH are struggling to improve local practice. The QSR measures key child and family outcomes and system practice performance. Recent performance is reflected below.

Current performance in the third cycle, after eight office reviews, indicates that:

- 56% of children are making acceptable progress toward permanency
- 74% of children are considered to have acceptable emotional well-being
- 40% of families are making acceptable progress toward adequate functioning
- 9% of children have a functioning family team
- 44% of cases have an overall adequate assessment
- 35% of cases have a long-term view of child and family goals and strategies

- 31% of cases have plans adequate for achievement of case goals
- 55% of cases are adequately tracked toward achievement of goals

Recommendations

1. Ensure the Immediacy and Intensity of Intensive Home-Based Mental Health Services

The Panel has been encouraging DMH and DCFS to collaborate on data-driven improvements in the responsiveness of IHBS, especially to prevent placement in emergency shelter, group home, residential facilities and psychiatric settings and placement disruptions, including the speed of identifying the child's needs, making an IHBS referral, and IHBS beginning services, and whether services were provided as many hours a week as necessary to meet the child's needs and support both the caregiver and the parent in visits in meeting those needs.

Specifically, the County should take the following steps:

- As soon as DCFS recognizes that a child's placement may disrupt or a child is being considered for a higher level of care, an immediate referral to IHBS should be made (not delaying for lengthy triaging or committee process).

- IHBS should begin providing services immediately to address the child's needs and provide support to caregivers to prevent disruption.

- IHBS services should be designed immediately with a "whatever it takes" approach, with daily in-home services for the child and caregiver if necessary. A pre-defined team of mental health staff should not determine what services or their intensity are provided—staff assignments should be unique to the child and family, with some children receiving daily 1:1 services, some caregivers having no parent partner, some families having the assistance of parent partners in visits and sometimes trauma treatment with guidance from the child's therapist for the caregiver and family being the primary service initially.

2. Develop Additional Measures that Reflect IHBS Quality and Effectiveness

The County should develop the capacity to expand its data collection and analysis to include new performance and outcome indicators for intensive home-based mental health services. These indicators might include the following, some of which are already reported.

Indicators reflecting service timeliness (beyond just initial contact)
Indicators reflecting service intensity
Indicators reflecting service duration
Indicators reflecting service tailoring
Indicators reflecting placement stability
Indicators reflecting placement level
Indicators reflecting duration of restrictive placement stays
Indicators reflecting runaway incidence and duration

3. Strengthen Training and Coaching

For staff in all DCFS regional offices and DMH providers to practice according to the SCPM requires (1) identifying each child's unique needs, including trauma-related needs, in discussions with families and caregivers and the rest of their team; and (2) crafting unique services and supports to meet each child's needs, including support for parents and caregivers in meeting the child's needs, and building on child and family strengths. Guiding strengths/needs-based practice relies on coaches and supervisors in DCFS regional offices and DMH providers, and as a result, a range in practice is coached and supervised. For the culture change DCFS and DMH leadership recognize is necessary, supervisors must become more confident in consistent approaches to teaching staff to guide families and teams in reaching agreement about children's underlying needs and crafting unique services and supports. Agreement about children's underlying needs and crafting unique services and supports should be apparent in CFT plans, DCFS case plans, DCFS court reports and mental health treatment plans.

Caseloads in the four DCFS immersion offices are dramatically reduced, and hiring and Academy training is resulting in decreasing caseloads in all the offices. More and more DCFS staff (and DMH providers) are learning how to facilitate a CFT meeting. Now the County has to enable CSWs to regularly utilize CFT meetings for all children and families throughout the family's experience with the system. The recent DCFS report on the frequency with which families experienced multiple CFT meetings confirmed that their incidence remains disappointingly low. Most families must experience more than an initial CFT meeting. The union's resistance to committing to this practice has long been a barrier to achieving compliance in this area.

Specifically, the County should take the following steps:

- Ensure sufficient coaching and training in strengths/needs-based service crafting is provided to supervisors in DCFS and DMH and that they consistently guide the staff in their units to children's include children's underlying needs and unique services and supports to meet those needs in CFT plans, DCFS case plans, DCFS court reports and mental health treatment plans.

- Ensure sufficient coaching is provided to supervisors so that they consistently monitor that each family in each worker's caseload has had more than the initial CFT meeting and is having CFT meetings often enough to arrange unique services coordinated with both the parent and caregiver and together assess whether they are the right services at the right frequency.

4. Increase Placement Resource Capacity and Stability

DMH and DCFS view their commitment to prevent the trauma of disruption for children as being reflected in the steps taken to develop an Automated Community-Based Home Reservation system, interagency collaboration (that unfortunately does not include Family Foster Care Agencies) to keep children close to their families, school-based recruitment of foster parents, and designing IHBS specifically to prevent each child from having a disrupted placement. Child well-being will be enhanced if each newly placed child remains near the parent with whom reunification is being planned and if the child does not have to change schools. This requires a major change from the past management of foster care placement, especially as the supply of homes has been shrinking.

Improving the quality of visits is a key ingredient to safe reunification. Visits are improved when there is shared parenting between parents and caregivers, with agreement between them about the child's needs and how to meet those needs, both in visits and in the caregiver's home.

DCFS offices have increased efforts to place children in family settings rather than group care, and the Panel has encouraged a new analysis of children in group care, reasons for their placement in the past year, and assessment of adequacy of mental health services for children in group care.

Specifically, the County should:

- Track any increase in placement changes within each office catchment area and identify the factors that make such placements a challenge to sustain

- Direct each immersion office to work with their FFAs to develop a plan for recruitment of additional family foster homes and place children close to home.

5. Expand the Use of the Automated Community-Based Home Reservation System.

This system informs DCFS staff where foster home vacancies in state-licensed homes exist system-wide. The County has been piloting a revision in this process for selected sites, whereby foster home vacancies in nine sites are reserved for that regional office for seven business days to permit the site to use them first. After seven days the vacancies are available system-wide. DCFS has recently implemented an improvement in which there is an automatic alert to staff when a vacancy occurs. The Panel views this innovation as promising in its ability to place children closer to their homes and communities.

However, it has significant limitations in that the majority of family foster homes are licensed by private family foster care agencies (FFAs) and these agencies are not included in this application. According to the DCFS, the following table reflects the distribution of family foster homes between state-licensed homes and FFA-licensed homes as of 2017.

State-Licensed Foster Homes			**FFA Homes**		
Available Homes	Available Beds	Placed Children	Available Homes	Available Beds	Placed Children
954	2,476	**1,838**	3,195	7,366	**4,736**
		(74.2%)			(64.2%)

For the placement system to serve all class members, the application would need to be extended to apply to FFAs as well.

The Panel recommends that DCFS formally approach FFAs about applying the process to their agencies as well.

6. Strengthen the Supervisory Role in Shared Core Practice Model Implementation

The County should develop a supervisory process that guides supervisors in mentoring CSMs and holding them accountable for performance in the CFT process, identification of underlying needs and matching services and supports to needs through service crafting. This process would likely involve case file reviews and court reports (work products) and supervisory case conferences

(supervisory forums) as ways to assess performance and skill development needs, underscore accountability and teach workers SCPM skills. The development of a supervisory guide would help structure this process. Supervisors would need training/coaching themselves to fully master this element of the supervisory role. The Panel does not believe that the County can meet QSR exit standards without addressing this vital supervisory role, which is not currently being performed on an ongoing basis beyond the CFT facilitation coaching, which is quite limiting. Continuing low QSR performance in these areas provide clear evidence of the necessity of implementing such supervisory review and mentoring.

7. Complete the CFT Tracking Application

The County should complete the development of a CFT frequency tracking system that provides management data on the performance of CSWs and the percentage of youth and families that have experienced a CFT in the past three months. As part of implementing this process, the County needs to issue policy guidance outlining how staff determine if contacts with families constitute a legitimate and reportable CFT. Because functional CFTs can take varying forms, policy guidance that provides for this variability would need to be carefully crafted, probably consisting of principles. The following examples have been shared with the County by the Panel previously.

Principles of SCPM CFT Meetings

Are usually planned in advance, with participants prepared/notified in advance

Entail ongoing communication among team members before and after team meetings to ensure follow up on service plans and other actions decided by the child and family team

Always involve the family

Should include a family support or supports member chosen by the family

Should include the CSW (with some exception for weekly Wrap meetings) and at least one other team member other than the family. (Teams usually grow in size over time)

Should include the caregiver (kin or foster family)

Should include key providers such as the child's therapist and school team member, where needed

Are strength and needs-based

Identify the strengths of the child, family and caregiver

Identify the needs of the child

Are outcome focused

Specify services to meet the child's needs

Specify supports for the family (during visits) and the caregiver to meet the child's needs

Result in notes about the decisions made in the meeting provided to participants

Result in an agreed-on plan with strengths, needs and supports and services

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I. Introduction

The following Report to the Court outlines the County's progress toward achieving the objectives of the Katie A. Settlement Agreement and includes a description of its compliance with the current Joint DCFS/DMH Plan, Corrective Action Plan and the Strategic Plan. The court will recall that in late 2014, the County, plaintiffs and Panel began to discuss strategies to accelerate Katie A. implementation by undertaking an "immersion process" whereby the County would select two offices/regions per 18-month period in which there would be more intensive supports and resources invested to accelerate implementation. The County adopted this approach because of limited progress to date and the large size of the County, which makes it difficult to bring intense resources to bear in each jurisdiction simultaneously, and to provide an environment where innovation can be tested prior to implementation throughout the County. The first immersion offices were Compton and Van Nuys. The second two sites scheduled for immersion were Pasadena and Belvedere. Their immersion implementation is now underway. Current immersion plans involve expansion of Intensive Home-Based Mental Health Services County-wide, and additional staff, service resources, training and coaching devoted to the immersion sites.

Since the 2016 monitoring and reporting period ended in December 2016, to make the report more relevant to the court, updates to implementation status extend to June, 2017. It is anticipated that the immersion process will continue, two offices at a time, until Katie A. is fully implemented system-wide. Implementation in non-immersion offices is expected to be slower until they begin immersion.

Panel Report Background

Some background is useful in reviewing this report. This report covers the 2016 monitoring and reporting period. There is always a lag between the end of the reporting period and the publication of the report while end-of- year data is being collated by the County. As a result, the information in monitoring reports is somewhat dated. To make the report more current, some current information on implementation efforts is also included.

Second, of necessity, some County implementation strategies within the Strategic Plan have been revised because of experience with earlier efforts, new challenges and new initiatives. Performance on some of these early strategies reflect substantial compliance, such as in establishing the Medical Hubs and providing mental health screening to children served by DCFS. At this point the Panel monitors ongoing performance in areas such as these to assure that progress is sustained. Some of the newer implementation strategies underway are not reflected in the original Strategic Plan, but are considered by the parties to be functionally part of current planning. The Panel monitors and reports on these as essential functional revisions to the Plan.

Third, because of its limited capacity to continuously track and verify operations within DCFS and DMH, the Panel is unable to generate its own quantitative evaluative data on which to base its appraisal of County performance under the settlement. As a result, the Panel relies on County data to judge quantitative and some qualitative trends on system performance, outcomes and compliance. The County is asked to provide relevant data and its own analysis of trends, which the Panel utilizes in its reports. As a result, much the content of Panel reports consists of County-produced data, which the Panel has also analyzed. The County updates are presented in a smaller font size than the Panel's analysis, observations and recommendations.

II. 2017 Strategic Plan Update

The County has now undertaken a series of strategies in an effort to "harmonize its obligations under the 2003 Settlement Agreement; the 2008 Strategic Plan; the Immersion approach; and ongoing changes in state law." The County presented its conceptual approach to the Panel in June, 2017 as follows.

County 2017 Strategic Planning Update

IMMERSION STRATEGIES

STRATEGY 1: SHARED CORE PRACTICE MODEL

A. COACHING CAPACITY TIME FRAME FOR INSTENSIVE MENTAL HEALTH PROVIDERS

As part of the FY 17-18 Budget process, Los Angeles County's Chief Executive Officer approved the Department of Mental Health's (DMH) request for 48 additional coaching, Quality Service Review (QSR), and support staff. While DMH is developing a hiring and training plan for these new positions, DMH's Budget request is concurrently proceeding through the County Budget approval process, which will conclude in June 2017. An additional means to expand DMH's coaching capacity will be through the cross-training and coaching of new staff, hired to support the transition of Wraparound program and contract administration from the Department of Children and Family Services (DCFS) to DMH. ***(Please see Appendix I - Coaching Capacity time frame for Intensive Mental Health Providers.)***

B. DCFS ACADEMY

There are two primary training venues for DCFS staff.

1. **The DCFS Academy** is a 52-week learning experience for newly-hired DCFS Children's Social Workers (CSWs); within which 10 weeks are comprised of classroom experience under State-prescribed curriculums.
2. **The DCFS University** offers continuous training opportunities for all existing DCFS CSWs and Supervising Children's Social Workers (SCSWs).

An exclusive 4-hour class on strengths/needs-based service crafting is offered through the DCFS University, where it is available to all existing DCFS staff. Panel member Dr. Marty Beyer was instrumental in supporting curriculum development for the 4-hour class. Module 1(a) for Child and Family Team (CFT) certification of practitioners was revised to include elements of the aforementioned 4-hour class.

While strengths/needs-based service crafting is not exclusively taught at the DCFS Academy, its principles are interwoven throughout the curriculums of Academy modules on CFTs; motivational interviewing; and individualized service planning. Additionally, the State is mandating field activities within the Supervisor Core Training related to coaching CSWs on strengths/needs-based service crafting, which the State calls "individualized service planning."

Finally, a countywide coaching team supports Shared Core Practice Model (SCPM) implementation and skills-building through intensive coaching for CSWs and SCSWs throughout DCFS Regional offices. The countywide coaching team conducts CFT Skills Labs and SCPM skill-building, which have proven effective in improving practice. Skills Labs will be serially held throughout all DCFS Offices. Furthermore, the coaching team has pulled 50 action plans from CFT

meetings to analyze and further inform DCFS training and coaching. Finally, the DCFS research team is developing an evaluation to identify departmental progress, gaps and continued needs associated with SCPM implementation.

C. ACHIEVING STRENGTHS/NEEDS-BASED PRACTICE

DCFS and DMH remain committed to implementing the "Los Angeles County Shared Child Welfare/Mental Health Core Practice Model," developed in September 2012. In so doing, both departments are forging ahead with training and coaching CSWs and mental health providers on identifying each child's unique underlying needs and crafting formal and informal services and supports to both meet the child's needs as well as to support the child's caregiver in meeting the child's needs. As the County continues evolving into a trauma-informed and trauma-responsive system, Los Angeles County's training and coaching curriculum, consistent with the State's Core Practice Model guidelines, focuses on assisting CSWs and practitioners in understanding:

- How a child's needs drive his/her behaviors;
- That needs are not services; and
- How uniquely-crafted interventions, viewed through the lens of trauma, will meet the specific and unique needs of the child and support the child's caregiver in meeting the child's needs.

The State of California, through its obligations under its Katie A. Settlement, has changed the manner in which child welfare and mental health services are delivered statewide. One of the fundamental aspects of Continuum of Care Reform (CCR), implemented through AB 403, is that child welfare services are most effective when delivered within the context of a CFT. The State has provided detailed guidance as to the manner and frequency each CFT meeting is to be conducted. DCFS and DMH are currently in the process of aligning statewide mandates and requirements associated with Child and Family Teams related to "consistent" and "regular" utilization.

In April 2016, DCFS issued departmental CFT policy. As of June 1, 2017, DCFS had certified 2,208 SCPM practitioners, as follows:

	SCPM PRACTITIONERS	SCPM COACHES	SCPM COACH DEVELOPERS	TOTAL	%
CSWs	1,494	20	3	1,517	58%
SCSWs	171	360	63	594	120%
OTHER (RA, ARA)	74	15	8	97	-
TOTAL	**1,739**	**395**	**74**	**2,208**	-

DCFS projects reaching 100% SCPM Practitioner certification of all CSWs by December 2018.

To track and monitor the post-certification activities of its SCPM practitioners, DCFS is refining a database that compiles information on Child and Family Team meetings.

DCFS and DMH acknowledge that informal supports are as essential to meeting each child's underlying needs as formal mental health interventions. Therefore, we remain committed to enhancing the ability of CSWs and mental health providers to individualize treatment and case plans with "out-of-the-box" interventions, services and supports. Additionally, the County considers the strengths/needs-based approach to family visits a valuable goal. However, there are many issues - staffing, resources, and funding - that require further exploration prior to implementing such a recommendation.

Finally, the realities of Medi-Cal re-imbursement, legally-sufficient Court report language requirements, and competing state mandates continue to challenge the documentation process. To address this reality, on an ongoing basis our CFT training and coaching staff work with mental health providers and CSWs to underscore the importance of capturing the child and family's strengths; needs; long-term view; and individualized interventions and services. DCFS is developing training on how to document these elements in the CFT Matrix instead of in mental health treatment plans, court reports and case plans.

D. INCREASED PLACEMENT RESOURCE CAPACITY

DCFS and DMH recognize that successfully placing children in homelike family settings within community of origin relies upon an adequate supply of appropriate placement resources and appropriate services and supports for caregivers. For that reason, DCFS continues to pursue implementation of the Quality Parenting Initiative (QPI) as a strategy to increase and maintain quality placement resources.

To more effectively manage the placement/replacement process, in February 2017, DCFS tested and successfully automated a "Community-Based Home Reservation" system. Through this system, the DCFS Permanency Resources Division alerts a DCFS Immersion Office of newly-approved local homes; and the automated reservation system "reserves" the home for five business days, availing it only to the Immersion Office for that reserved period. The system also monitors how quickly and often the Immersion office utilized the reserved home to locally-place a child.

Additionally, DCFS is partnering with the Los Angeles County Office of Education (LACOE) and the Los Angeles Unified School District (LAUSD) to ensure school stability for foster children placed outside their communities of origin. A pilot transportation program began in May, 2017, and will run through December, 2017. For children whose caregivers are unable to transport them to and from their schools of origin, LACOE will coordinate school district-to-school district transportation using school district transportation resources or through a contract with a car service. Data will be maintained throughout the pilot, which is being jointly funded by DCFS, LACOE and LAUSD.

To comply with CCR mandates, DCFS offices have increased efforts to place children in family settings rather than group care. To support the work, DCFS has completed an office-by-office analysis of group home-placed children, ages 5 and under; 6-11, and 12 and older, which also details length-of-stay in congregate care and the mental health services to which the children/youth are connected. DCFS identified an initial cohort of 109 children/youth placed in RCL 11s and lower, who are in the Family Reunification or Adoptive Planning phases of service delivery.

The case-carrying CSWs of the 109 children/youth have been instructed to explore these children's/youth's safe and stable transitions to lower levels of care through the CFT process. Group Home staff will be invited to be join the CFT. Additionally, in order to centrally manage the safe and appropriate reduction of Group Home-placed children, DCFS made the decision to re-purpose its D-Rate Evaluators. D-Rate Evaluators will be renamed; and their re-purposed role will be to work closely within the Coordinated Services Action Team (CSAT) to centrally oversee entries and timely exits of all DCFS-supervised children placed in residential care.

DCFS and DMH remain committed to ensuring children and youth have timely access to the essential services and supports necessary to prepare children and youth for a successful transition into adulthood. As we progress through CCR implementation, we will collect relevant data to inform policy and operational decisions that will improve child welfare outcomes

STRATEGY 2: EXPANSION OF IHBS and ICC

A. REFERRALS TO IHBS & IHBS RESPONSIVENESS

The speed of responsiveness to both initial referrals and crisis intervention is critical. The shift in responsibility for the Wraparound contracts allow for streamlined protocols and development of consistent guidelines across ICC and IHBS programs - Wraparound, Full Service Partnership (FSP), and Intensive Field-Capable Clinical Services (IFCCS). This process is anticipated to be completed before the end of calendar year 2017. DMH and DCFS have worked together to improve access to care through multiple strategies, some of which include:

- Simplified the referral process for CSWs by streamlining the referral form and ensuring one process to access all ICC and IHBS services through CSAT.

- Created consistent expectations across ICC and IHBS services for face-to-face contact within 24 hours for all first-time referrals, with exceptions made for family accommodation. Children, youth, and families in crisis will have immediate access to services through a rapid referral process or through DMH's SB 82 teams, discussed later in this document. This new language will be in effect once Wraparound contract amendments are signed, anticipated by the end of the fiscal year.

- Identified children and youth with high-risk identifiers. DCFS is working with their case-carrying CSWs, on a case-by-case basis, to increase their mental health service intensity when appropriate.

Working in collaboration, DCFS RAs and DMH Specialized Foster Care Program Heads in each DCFS Office are ensuring that CSWs are aware of ICC and IHBS services; their benefits; and how to access them. ***(Please see Appendix IV - Trend Data on Filled IHBS Slots.)***

We are pleased to announce that the above strategies realized increased IHBS service connections across all programs, as follows:

IHBS PROGRAM	SLOT CAPACITY	CY 2016 FILLED SLOT AVERAGES	Y-T-D- 2017 FILLED SLOT ACTUALS	VARIANCE
Wraparound	3,000	2,201	2,005	<7%>
IFCCS	780	165	515	+45%
FSP	1,771	1,273	1,469	+11%
TFC	300	78	81	+1%
TOTALS	**5,851**	**3,717**	**4,070**	**+6%**

Once the Wraparound contracts are fully managed by DMH, all ICC and IHBS services will include a contractual expectation of 24/7 immediate field-based response when crises occur for enrolled children. In addition to mental health crises, field response is expected when a disruption in the home puts the placement in jeopardy. DCFS and DMH are working together to identify their "hunch" criteria and identify resources to manage crisis calls. DMH is examining options to streamline and centrally track 24/7 response for need and response time. For those children and youth not already connected with an intensive mental health service provider, DMH and DCFS developed a proposal to receive services from a separate, contracted ICC/IHBS team that will work with the child and family until the child/youth is connected with appropriate services.

Finally, to better understand the circumstances around placement disruption, DMH and DCFS continue collaborating on the review of the 29 IFCCS cohort group presented during the March 2017 retreat. DMH is working with DCFS programmatic staff and DCFS research staff to detail the history prior to ICC/IHBS access and continued status post enrollment. DMH and DCFS are reviewing the outcomes of each case through interviews with the youth, CSWs and service providers. The goal of this project is to gain systemic insights to share with DMH and DCFS executive management on precipitating factors for placement disruption and to inform protocol revisions.

DCFS and DMH leaders will meet regularly to review and discuss joint learning from the cohort study, the crisis response protocol, and our collective impact on placement stability.

B. IHBS DELIVERY

DMH is committed to providing quality intensive mental health services to all children, including system-involved youth. DMH, DCFS, and Probation, along with ICC and IHBS provider representatives, meet regularly to standardize access to and delivery of ICC and IHBS services – Wraparound; IFCCS and FSP. However, pooling all ICC and IHBS programs presents administrative challenges because the three programs have separate funding streams and reporting obligations.

Our collective goal is to create consistent service delivery standards and a single process for access to care. Systemic issues, including the use of different programmatic funding streams and the mental health agency contracting process, contribute to the Department's need for flexibility in program design. We believe that no family is best served using a single formula and that there is value to having a variety of features to best meet the needs of children and families. DMH and DCFS continue their work together to address disparities among programs to ensure the best features of each program are available across the service spectrum. We anticipate this process to take time, as we've recently begun to work to set clear standards for ICC and IHBS services and to hire resources to provide much needed coaching and training.

STRATEGY 3: QSR AS A TEACHING TOOL FOR CORE PRACTICE MODEL

Over the past six years, Los Angeles County has greatly improved its child welfare program and the delivery of services to youth. However, a lack of corresponding progress in QSR scoring has created frustration and questions about the validity of its measures. The QSR has not been effective as a compliance tool in Los Angeles County; and use of this tool for this purpose has retarded acceptance of QSR as a teaching/feedback mechanism.

The QSR Sum Up sessions continue to focus on ways to utilize QSR as a teaching and training tool. One tool that was developed is the Teamwork Matrix that clearly and simply describes what is working in each case, as well as identifying the learning opportunities. Additionally, a Positive Practices handout was presented to highlight good work already in progress.

Training sessions have expanded during the Third Round in an effort to support the offices' interest in understanding the process and prepare them for the upcoming review. For example, a few offices have requested more in-depth training by

QSR staff to motivate and support CSWs. The Departments remain committed to cross-training Coaching and QSR staff through a SCPM lens to ensure a consistent message across the regional offices.

Additionally, the Departments are open to discussing the redesign of the Grand Rounds process. Coaching Sessions by the Panel would also be helpful to discuss this in greater detail. As the departments add staff to the DCFS Quality Improvement and DMH QSR and coaching units, it further increases the capacity for Regional Administrators, Assistant Regional Administrators and DMH managers to act as shadow reviewers.

DCFS and DMH continue their commitment to the QSR as a teaching tool to review SCPM implementation. DCFS and DMH believe that the QSR is a valuable tool for service and practice improvement in Los Angeles County; and is committed to utilizing it in that manner. However, we would like to further explore SCPM implementation compliance measures that align with state mandates; more accurately review compliance progress; and focus on child and family well-being and outcomes as measures of our success.

CRISIS RESPONSE & PLACEMENT STABLIZATION PROPOSAL

BACKGROUND

Placement stability is vital to promoting resilience, well-being and a positive quality of life. A substantial number of Department of Children and Family Services (DCFS) detained children living in Los Angeles County have experienced trauma, abuse and neglect and are coping with multiple placement disruptions. Each month the Department of Mental Health (DMH) Psychiatric Mobile Response Team (PMRT) receives approximately 300 calls to evaluate children and youth involved in the child welfare system, most of whom would benefit from crisis support to preserve their placement and address the family and child/youth's behavioral needs, rather than hospitalization. DCFS and DMH believe that a majority of these children's unmet underlying needs may contribute to placement disruptions.

While many of these children/youth are linked to intensive mental health programs, when there are multiple placement disruptions, their caregivers may be unaware of the 24/7 response component of the program. There is a subset of children/youth who are not enrolled in intensive mental services who experience a crisis that warrants immediate response to the placement. Providing access to crisis intervention services is critical when a placement is jeopardized due to unaddressed underlying needs and behaviors.

It is evident that the two Departments must continue collaboration to help children/youth maintain placement. To achieve this goal, a joint task force comprised of DMH and DCFS Administrative staff, based on the previous crisis workgroup, will be established to further develop and implement the crisis response protocol.

TASK FORCE GOALS

DCFS and DMH leadership determined the following three goals must be met for an expedited response protocol to be effective:

- Establish instant, real time telecommunications between DCFS and DMH staff
- Allow for the free flowing exchange of DMH and DCFS client information
- Ensure that children/youth who have been evaluated, but not hospitalized, are linked to any mental health services that will address their needs.

In addition to the Task Force the Departments are also proposing to develop the program outlined below.

PROGRAM PROPOSAL

To increase access to crisis response services, DMH Children's Systems of Care (CSOC) Administration and DCFS Administration proposes the development of:

1. A central triage team to manage crisis response requests, and
2. Trauma-sensitive/informed mental health crisis teams to engage and link children/youth who are not enrolled in intensive mental health services developing.

PROPOSED CRISIS RESPONSE PROTOCOL

DMH ACCESS staff will triage crisis calls for DCFS involved children ages birth to 21. Upon receiving a call from DCFS (e.g. CSW, Caretaker, etc.), the triage staff will determine if the child:

- Requires a 5585 evaluation by PMRT, **or**
- Is at risk of placement disruption due to mental health related behaviors and/or has been issued a seven day notice, **and**
- Is enrolled in an intensive mental health program.

Requires 5585 Evaluation
If the child/youth requires a 5585 evaluation, PMRT will be dispatched.

Risk of Placement Disruption or Issued a 7-day Notice (does not warrant a 5585 evaluation)

- If the child/youth is enrolled in an intensive mental health program, ACCESS will notify the existing provider who will immediately respond to the crisis.

- If the child/youth is not enrolled in an intensive mental health program, ACCESS will contact the Child and Youth Mental Health Crisis Team who will immediately respond to the crisis.

CHILD AND YOUTH MENTAL HEALTH CRISIS TEAM SERVICE DELIVERY
If the child/youth is assigned to a Child and Youth Mental Health Crisis Team, the Team must make face-to-face contact with the child/youth within four (4) hours to:

1. Begin providing Outreach and Engagement
2. Administer a trauma informed mental health screening to determine the level of services needed. The screening will determine if:

    - A Child and Youth Mental Health Crisis case will be open or
    - The child/youth will be referred to an intensive mental health program (e.g. Intensive Field Capable Clinical Services, Wraparound, or Child/TAY Full Service Partnership)

When the Team opens a case, the Team is responsible for providing short term services for up to 60 days or until the placement is stabilized. Services shall be available 24 hours a day, seven days a week. The Team will provide a full array of mental health services which may include:

- Crisis Intervention and de-escalation
- Bio-psychosocial assessment
- Intensive Care Coordination
- Intensive Home Based Services
- Individual and family treatment
- Assessment and treatment of co-occurring disorders
- Client Supportive Services
- Medication Support

PEER SUPPORT

DMH is currently developing a proposal to provide Peer support to children/youth experiencing a mental health crisis. Children and youth who do not have access to peer support through their service provider will have access to ongoing Peer support to engage, validate and normalize the child/youth's experience.

TRAINING

The ACCESS Center staff and the Child and Youth Mental Health Crisis teams must be trained and proficient in:

- Trauma informed crisis de-escalation
- Suicide Assessment, Interventions and Documentation
- The Shared Core Practice Model
- Intensive Care Coordination (ICC) / Intensive Home Based Services (IHBS)
- Commercial Sexual Exploitation of Children (CSEC) 101
- Mental Health First Aid (MHFA)
- Child and Family Team (CFT) meeting facilitation

SUMMARY

ACCESS Center triage teams and the Child and Youth Mental Health Crisis Teams will ensure the safety, permanence and well-being of DCFS detained children in Los Angeles County.

Panel Response

In response to receipt of the Matrix from the County, the Panel responded by asking the County to explain the reason for the development of the Matrix with the following questions. The Panel is in continuous discussion with the County about the relevance of these strategies to the Strategic Plan and the Settlement objectives, their prospects for improving performance and outcomes and their ultimate effect on current performance and exit expectations.

- What is the purpose of this document? Self-appraisal? Is this is a revised strategic plan for going forward?

- In what ways is the County proposing the Matrix would alter our work together going forward?
- Is it accurate to say that the Matrix concludes that the County has only six activities to complete (portions of #10, #22, #23, #31, #32, and #36)?

- Under #22, the County describes training and coaching in IHBS providers quantitatively. How is the County measuring the quality of coaching and training in DCFS and DMH, in terms of practice according to the Shared Core Practice Model (including engagement, long-term view and child and family plans that itemize child needs and the services crafted to meet each need and support families and caregivers in meeting needs)?

- Under #31, the County states that DMH outcome data will be reported, but does not indicate (a) how often and in what form (b) going beyond whether mental health services were provided to whether they were of sufficient intensity and (c) will mental health outcomes be analyzed by DCFS office in the context of number of subclass members, placement disruptions, group care placements, and time to reunification/permanency?

- Under #32, will the Country analyze not only whether the child was linked to mental health services but also the intensity of the services?

- Is it accurate to say that the Matrix concludes that having structures and processes in place, even if they are not producing adequate results, constitute full implementation? For example:

  #11 asserts that the County has completed the IHBS requirement by having more than 4,000 IHBS slots available, but tracking intensity of services and outcomes—particularly child well-being, permanency, and meeting children's trauma-related and developmental needs—had been previously included in implementation.

  #3 asserts that the County has completed CFT and other practice requirements by having increasing numbers of certified SCPM practitioners, but tracking satisfactory frequency, membership and outcomes of CFT meetings had been previously included in implementation.

It appears that the Matrix does not include targets previously included in the County's work, including:

- TFC (including higher rate foster homes with IHBS)
- Placement of children close to their school and family
- Reducing group care placements especially for younger children

What is the status of these goals in reference to the Matrix? - Examining the reason for disruptions and whether mental health services provided immediately with sufficient intensity were utilized to prevent each disruption and how such services can be used in the future to prevent another disruption.

III. 2015-2016 County Performance Updates – Prior Reporting Period

The following County update primarily describes progress through 2016.

DMH Service Provision to Class Members

DMH provided the following updates regarding service provision to class members.

DMH conducted an analysis to compare matched client data from the last three calendar years (2014-2016), to identify members of the Katie A. class and subclass and determine the levels of mental health services they were provided. The analysis used the definition of the class and subclass contained in the settlement agreement in the Katie A. State case. The data contains only class and subclass members who received mental health services with DMH. The department points out that there are some limitations on the accuracy and comprehensiveness of these data; 1) This report may not fully reflect all class members and mental health services provided, as providers have up to 18 months to submit claims. 2) DMH used two different methods to capture the number of youth that were psychiatrically hospitalized due to limited DMH data available. Overall, the data provides a useful view of mental health service provision in the County.

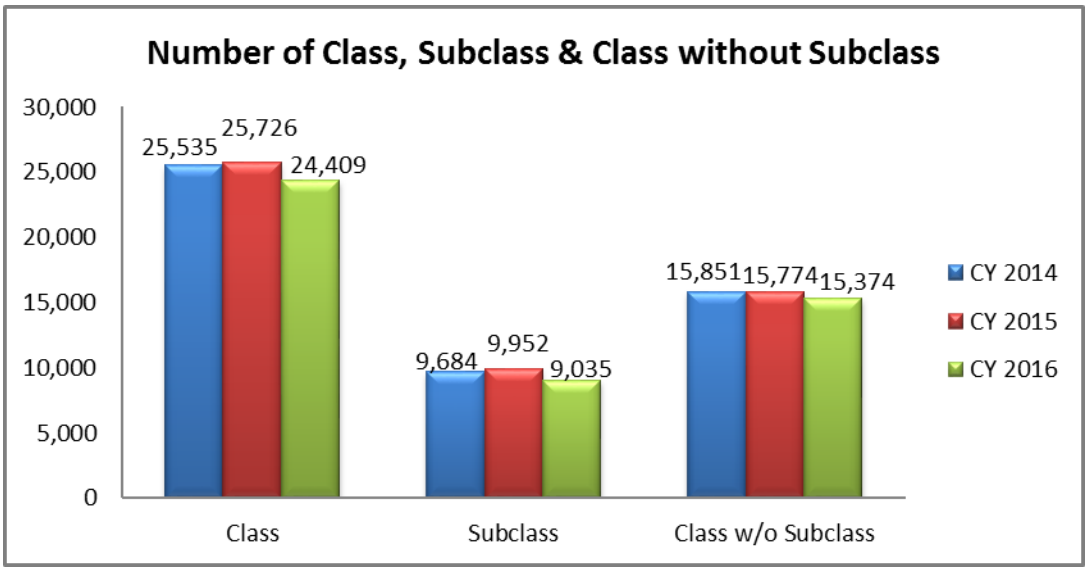
1) From the total number of DCFS clients in CY 2016 (55,521), 44% were Katie A. class[1] members, consistent with the previous calendar year (CY 2015, 44%). Of the 24,409 class members in CY 2016, 15,374 (63%)

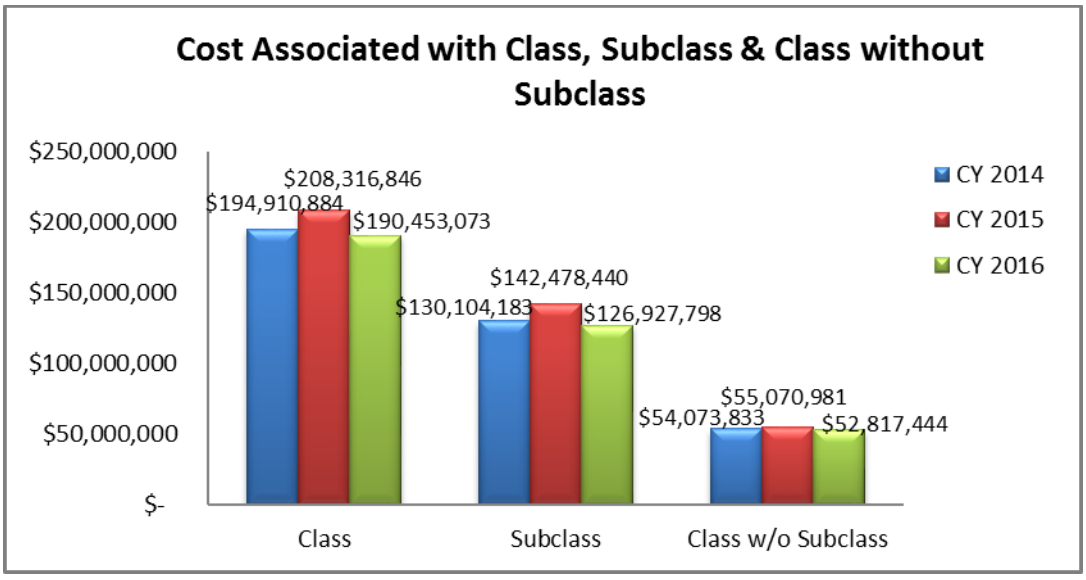
[1] Class: Children/youth who meet all of the following criteria: 1) Have an open child welfare services case; 2) Have full scope medi-cal; 3) Meet medical necessity for mental health services; and 4) Received a mental health service or were considered for Intensive treatment.

belonged to a category identified as Class without Subclass (Class w/o subclass: class members who are not part of the subclass). During CY 2016, about 37% of the Katie A. class were subclass[2] members and received more intensive mental health services, a decrease from CY 2015 (39%) and CY 2014 (38%). The data shows that the number of subclass members increased from calendar year 2014 to 2015 and decreased in 2016 (CY 2014: 9,684; CY 2015: 9,952; CY 2016: 9,035). This decrease in subclass members in CY 2016 seems to be largely due to a decrease in the number of youth that received three or more placements within 24 months (CY 2015: 5,481; CY 2016: 4,305). It should be noted that DCFS and DMH have difficulties in accurately capturing placement changes due to behavioral needs and the departments continue to refine processes to improve this data. The following graph shows the breakdown of the class, subclass and class without subclass for CYs 2014-2016.

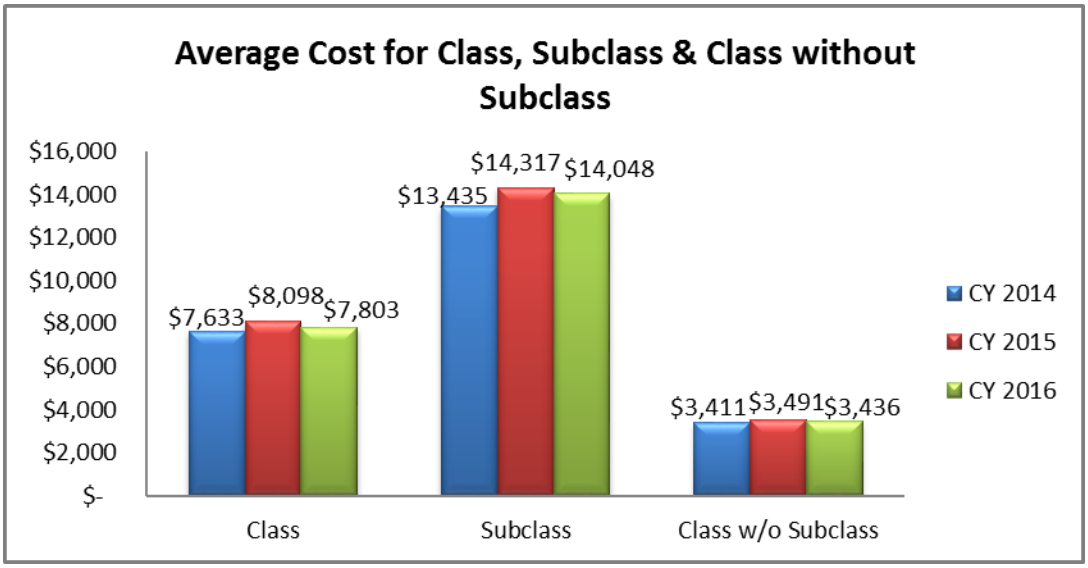
2) The cost associated with providing mental health services to the Katie A. class increased in CY 2015 and then decreased in CY 2016 (CY 2014: $195 million; CY 2015: $208 million; CY 2016: $190 million). The percentage of subclass costs slightly increased in 2015 and slightly decreased in 2016 (CY 2014: 67%; CY 2015: 68% and CY 2016: 67%). While the percentage of subclass to class members is slightly lower in CY 2016 than in CY 2014 (CY 2016: 37%; CY 2014: 38%), the percentage of the subclass costs is consistent with CY 2014, 67%. This data show that the number of class members meeting the subclass criteria has decreased since CY 2014, but this group has had an increase in intensive mental health needs based on the services provided to them. Overall, the mental health costs associated with providing services to the subclass group is still more than half of the total costs provided to the class w/o subclass.

[2] Subclass: Children/youth who meet criteria # 1-3 for the class above *and*: 4) Considered for or received *intensive* treatment, i.e., one or more of the following: a) Wraparound (Wrap), b) Intensive Field Capable Clinical Services (IFCCS), c) Full Service Partnership (FSP), d) Treatment Foster Care (TFC), e) Therapeutic Behavior Services (TBS), f) Had a psychiatric hospitalization, g) Received services through Exodus, h) Resided in a Community Treatment Center (CTF), i) Placed in a Group Home RCL 10 and above and/or, j) Had 3 or more placement changes in 24 months due to behavioral needs.





3) Upon closer look at the costs for mental health services that were provided to subclass members, the CY 2016 data shows the average mental health cost associated with subclass members ($14,048) has increased compared to CY 2014 ($13,435) and is still much higher than the average cost of mental health services for class members who are not part of the subclass ($3,436). The average cost for the class without subclass category has remained consistent in the last three years (CY 2014: $3,411; CY 2015: $3,491; CY 2016: $3,436). More specifically, subclass members are receiving more services than the average class member not belonging to the subclass.



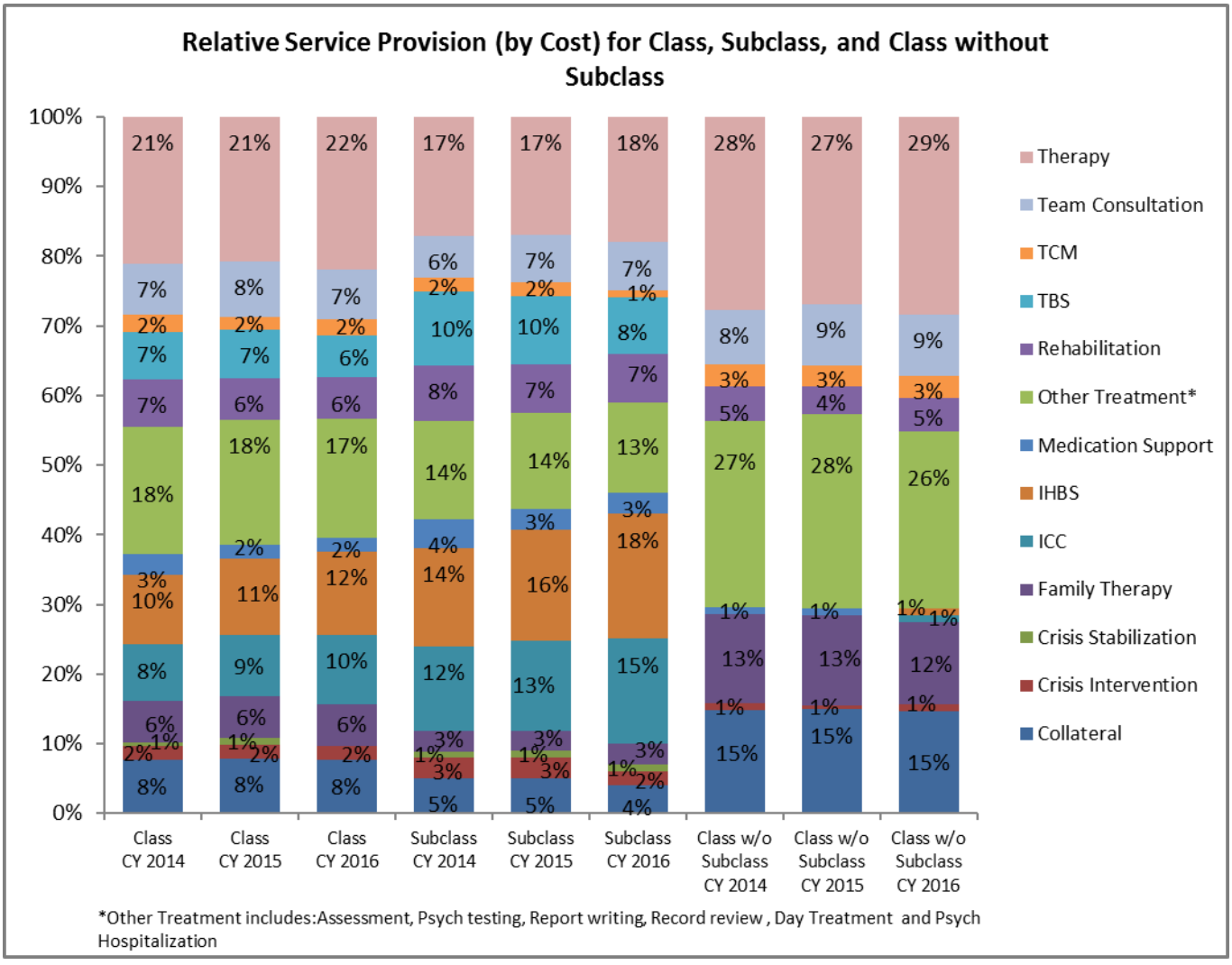
4) The mental health service array varies between class and subclass members. Services included in the array are Team Consultation (TC) and Therapeutic Behavioral Services TBS. TC is a case consultation or team conference, with or without the client present, with the purpose of plan development. It must include discussion regarding the client's progress, or lack thereof, in treatment and/or discussion of the client's plan for mental health treatment. TBS is an intensive, individualized, one-to-one behavioral coaching program available to children/youth up to age 21 who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.

In CY 2016, subclass members received less individual therapy than the class w/o subclass (Class: 18%, Subclass w/o subclass: 29%). Subclass members did receive more Targeted Case Management (TCM) including team consultation (TC) and ICC (subclass: 23%; class w/o subclass: 13%), and more rehabilitation services including TBS, collateral and IHBS (subclass: 37%; class w/o subclass: 21%).

In addition, within the last two calendar years, individual therapy for the subclass increased slightly (CY 2015: 17%, CY 2016: 18%), TCM including TC and ICC has increased (CY 2015: 22%; CY 2016: 23%) and rehabilitation including TBS, collateral and IHBS has decreased (CY 2015: 38%; CY 2016: 37%).

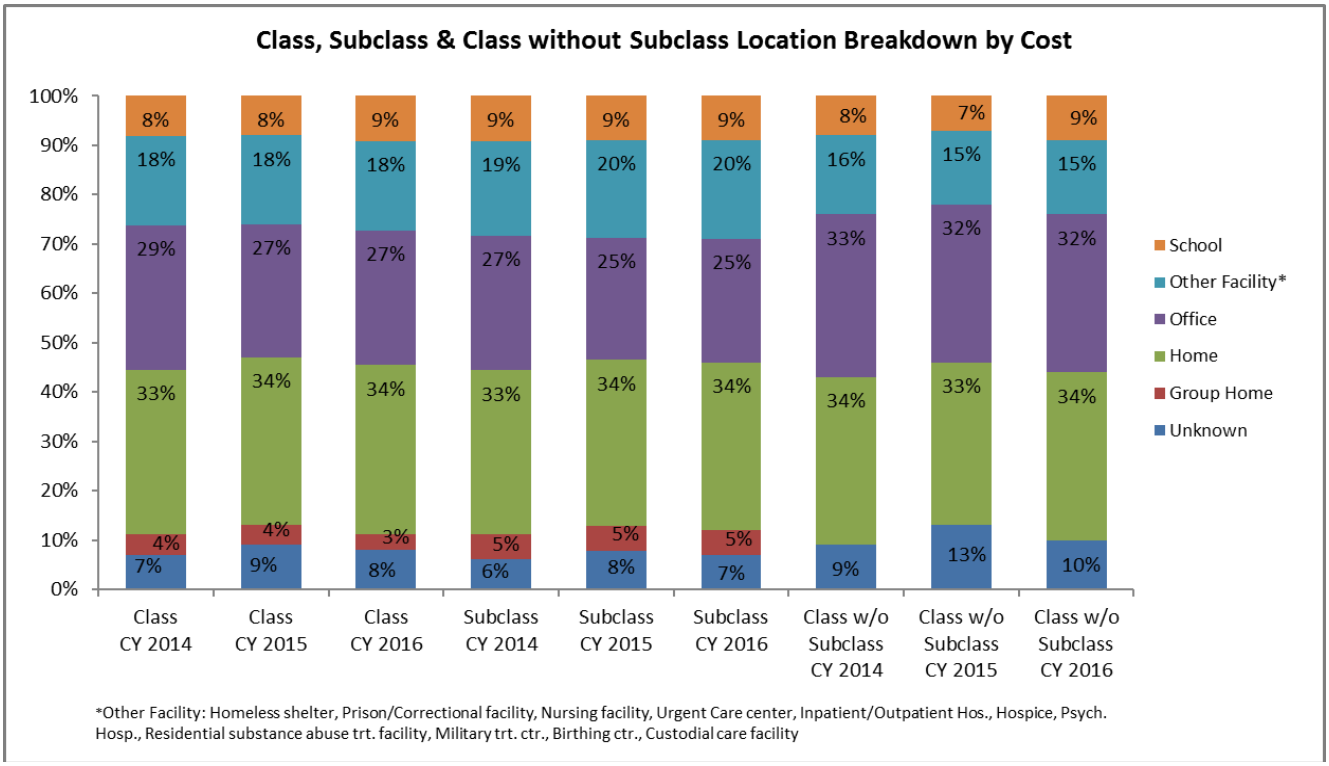
The mental health service array for subclass members is in line with the intensive services subclass members would be expected to receive. DMH hypothesizes that this type of service array would contribute to higher success rates for this population. The data does support an increase in ICC services in 2016 (CY 2015: 13%; CY 2016: 15%) and in IHBS services (CY 2015: 16%; CY 2016: 18%). DMH believes that there will be more subclass members receiving ICC and IHBS services in CY 2017 due to an expansion in the IFCCS and FSP programs. The IFCCS program was expanded from a 100 slot program to 780 slots in CY 2016 and Child FSP providers were allocated additional funding for 30% of their Katie A. slots. Each FSP provider will be accountable for providing a standardized service delivery system to the subclass.

DMH expects ICC and IHBS services to continue to increase as providers from these programs become more familiar with providing these intensive services to subclass members.



5) The data has been consistent and indicates that there are still more services being provided in the office for the class w/o subclass (CY 2014: 33%; CY 2015: 32%; CY 2016: 32%) than for subclass members (CY 2014: 27%; CY 2015: 25%; CY 2016: 25%). Also, more services are being provided in other facilities for the subclass (CY 2014: 19%; CY 2015: 20%: CY 2016: 20%) than for the class w/o subclass (CY 2014: 16%; CY 2013: 15%; CY 2016: 15%). This may be partly due to subclass members being in need of more intensive mental health services within other types of facilities like psychiatric hospitals and urgent care centers. In addition, while DMH expected to see an increase in subclass members receiving more services in the home during calendar year 2016 than 2015, the percentage was the same in both years (CY 2015: 34%, CY 2016: 34%). Last, the percentage of services offered in the home was the same for the class w/o subclass and for subclass members in CY 2016 (34%).

While there does not seem to be a trend in more services provided in the home for subclass members, they do receive more services in alternate settings (group home, school, other facility) than the class w/o subclass (CY 2016- Subclass: 33%, Class w/o subclass: 24%). It should be noted that for CY 2016, the location of services was unknown for the service claims of 8% of the Class, 7% of the Subclass and 10% of the Class w/o subclass. DMH believes that this is most likely the result of having two billing systems, the Integrated System (I.S.) and the Integrated Behavioral Health Information System (IBHIS). There have been some difficulties with pulling all information related to a claim, but as mental health providers transition to just one system, IBHIS, the unknown data percentage should decrease.



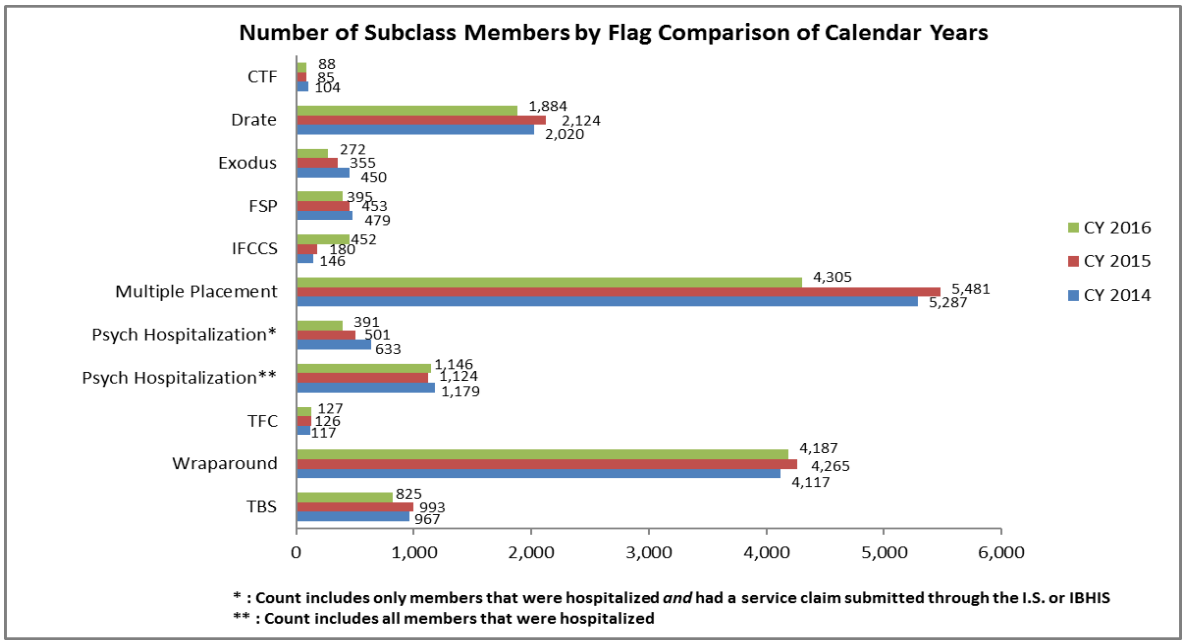
6) DMH developed the following chart that indicates the criteria or programs youth were in that contributed to them being in the subclass. In CY 2016, the majority of youth had three or more placements (4,305), were in Wraparound (4,187), or placed in a D-Rate home (1,884). Furthermore, many of the youth fell into multiple subclass categories.

Since CY 2014, more youth are enrolled in TFC (CY 2014: 117; CY 2015: 126; CY 2016: 127) and in IFCCS (CY 2014: 146; CY 2015: 180; CY 2016: 452). The following programs/subclass criteria saw an increase in subclass members in CY 2015 but then a decrease in CY 2016: 1) TBS (CY 2014: 967; CY 2015: 993; CY 2016: 825), 2) Wraparound (CY 2014: 4117; CY 2015: 4,265; CY 2016: 4,187), 3) Multiple Placement (CY

2014: 5,287; CY 2015: 5,481; CY 2016: 4,305), 4) FSP (CY 2014: 479; CY 2015: 453; CY 2016: 395) and 5) D-Rate(CY 2014: 2,020; CY 2015: 85; CY 2016: 88). Exodus is the only subclass criteria where there has been a continuous decrease in subclass members since CY 2014. (CY 2014: 450; CY 2015: 355; CY 2016: 272).

DMH should mention that the multiple placement category continues to be refined in an effort to be in line with the State's definition of this category (due to behavioral reasons). The data also shows that the number of youth placed in a psychiatric hospital has decreased; however, it is important to note that DMH continues to have difficulty gathering data regarding psychiatric hospitalizations and much of the data is missing or not accurately reported (hospital staff can bypass the I.S. and IBHIS and bill services directly to the State). The graph below includes two hospitalization counts: 1) Psychiatric Hospitalization*: This count only includes members that were hospitalized *and* had a service claim submitted through the I.S. or IBHIS; 2) Psychiatric Hospitalization**: This count includes all members that were hospitalized (regardless of whether a claim was submitted through the I.S. or IBHIS).

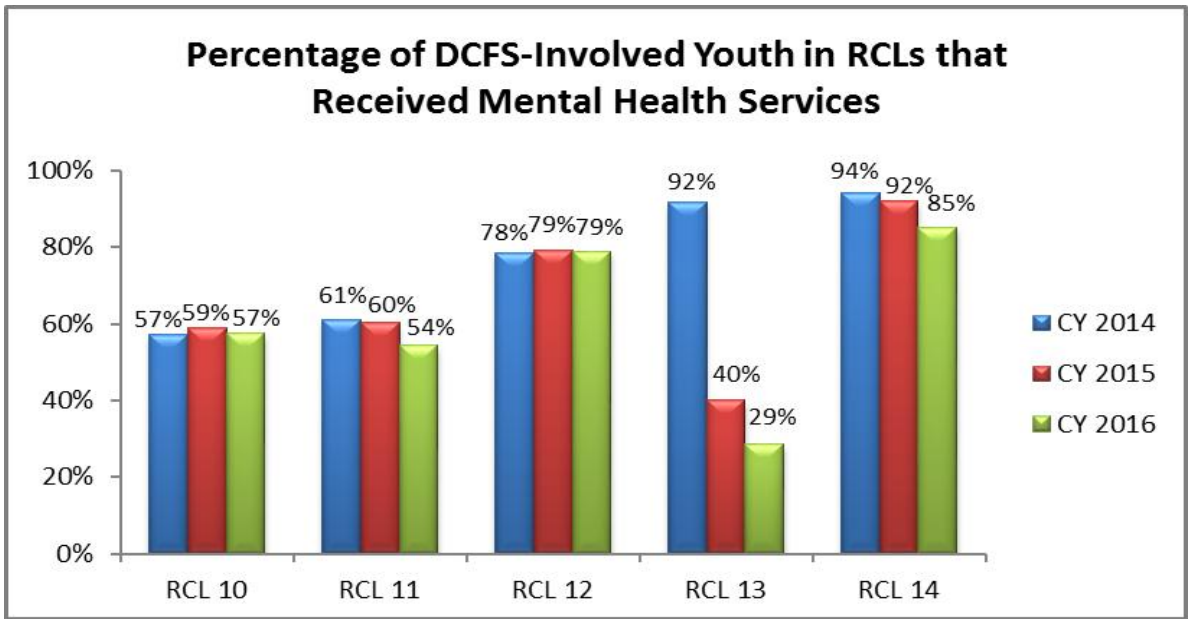
[The subclass criteria below include Full Service Partnership (FSP), clients that have had three or more placements within 24 months (Multiple Placement), Treatment Foster Care (TFC), Community Treatment Facility (CTF), D-Rate placement, Rate Classification Levels 10-14 (RCL 10–14), Psychiatric Hospitalization (Psych Hospitalization), Wraparound, Exodus, and/or Therapeutic Behavioral Services (TBS)].



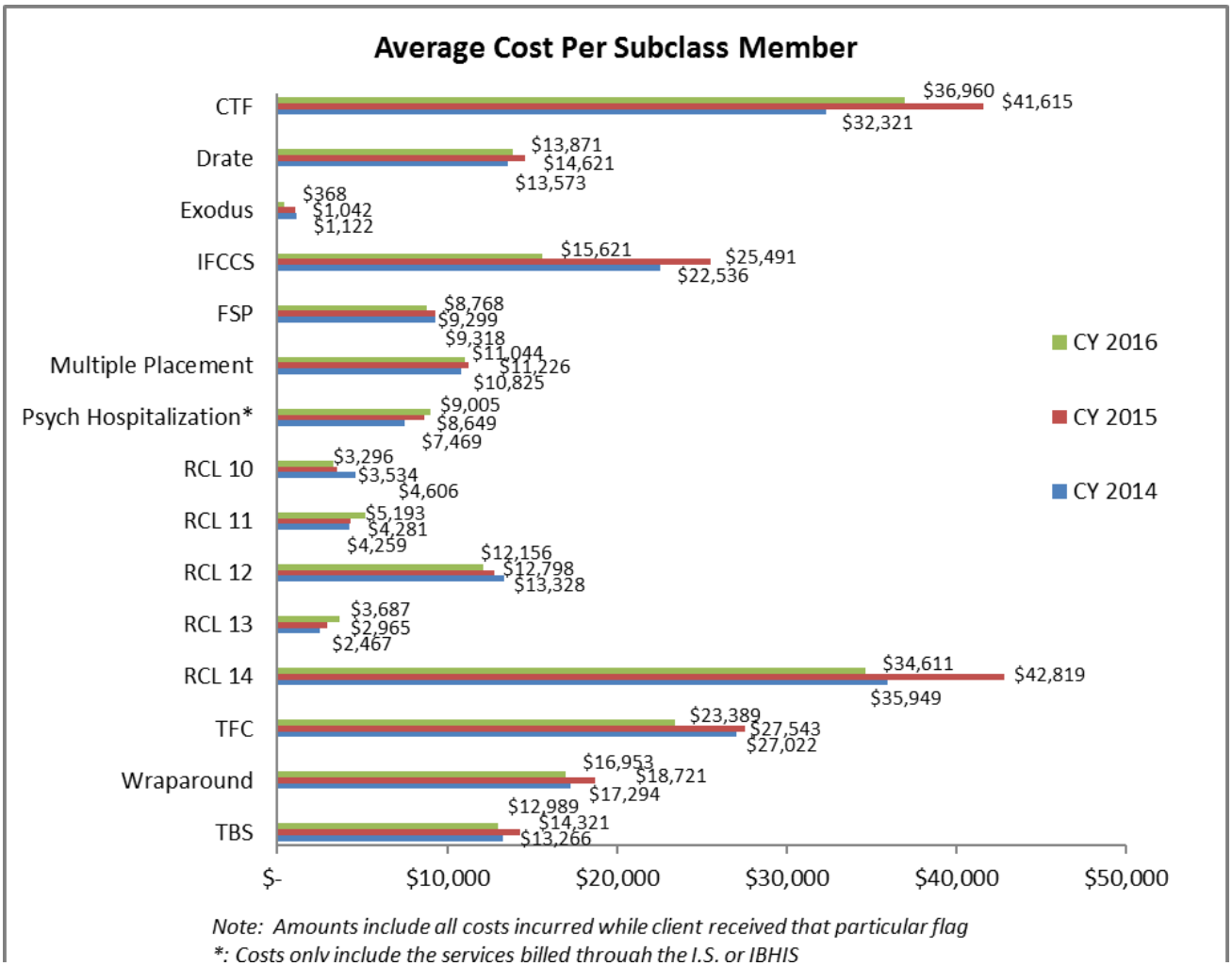
7) In the following data, DCFS' calendar year placement numbers were compared to DMH clients who received a mental health service while in Rate Classification Level (RCL) 10 and above. Many of the children placed in the RCLs may in fact be receiving mental health services from the Group Home staff members and/or Fee-for-Service Providers, which is not reported to our mental health database. Additionally, some of these children may have been placed in facilities located outside of the County and/or State; therefore, in these instances, their mental health information would not be reported to DMH.

The graph below shows the percentage of DCFS-involved youth in RCLs 10 and above that received mental health services through DMH. The data shows that within the last three calendar years, the percentage of youth that received mental health services through DMH remained steady in RCL 10 and RCL 12 (RCL 10, CY 2014: 57%; CY 2015: 59%; CY 2016: 57%), (RCL 12, CY 2014: 78%, CY 2015: 79%, CY 2016: 79%). The percentage of youth that received mental health services through DMH has decreased in RCLs 11, 13, and 14 (RCL 11- CY 2014: 61%; CY 2015: 60%; CY 2016: 54%), (RCL 13, CY 2014: 92%; CY 2015: 40%; CY 2016: 29%), (RCL14, CY 2014: 94%; CY 2015: 92%; CY 2016: 85%), It's important to note that less

children/youth reside in RCL 13 compared to the other RCLs (RCL 13, CY 2014: 12 residents; CY 2015: 10 residents; CY 2016: 7 residents).



8) The average cost associated with the subclass criteria or programs varies greatly, with costs associated with Community Treatment Facilities (CY 2016: $36,960), Rate Classification Level 14 (CY 2016: $34,611) and Treatment Foster Care (CY 2016: $23,389) being the programs with the highest costs for subclass members in calendar years 2014-2016 (see chart below). However, the costs of Psychiatric Hospitalizations only include the costs for claims that were submitted through the I.S. or IBHIS and do not include costs for services that the hospitals may have billed directly to the state. The costs below only include services billed under one of the procedure code groupers: Therapy, Family Therapy, Collateral, Crisis Intervention, Targeted Case Management (TCM), Therapeutic Behavior Services (TBS), Team Consultation, Rehabilitation, Intensive Care Coordination (ICC), In Home Based Services (IHBS), Medication Support, Crisis Stabilization, Other Treatment (Assessment, Psychological Testing, Report Writing, Record Review, Day Treatment and Psychiatric Hospitalization).



Utilization of Evidence-Based and Promising Practices

DMH reports that for CY 2016, 6,164 class members received treatment using an evidence-based or promising practice (EBP). This reflects a decrease from 7,841 in 2015 and 8,325 in 2014. In CY 2016, most class members received Managing and Adapting Practice (MAP) (2,163),
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (2,160), Child Parent Psychotherapy (CPP) (843) and Parent-Child Interaction Therapy (PCIT) (534). There has been a significant decrease in the number of class members that received Seeking Safety (SS) since CY 2014 (CY 2014: 1,107; CY 2015: 706; CY 2016: 393).

I. EBPs by Calendar Year

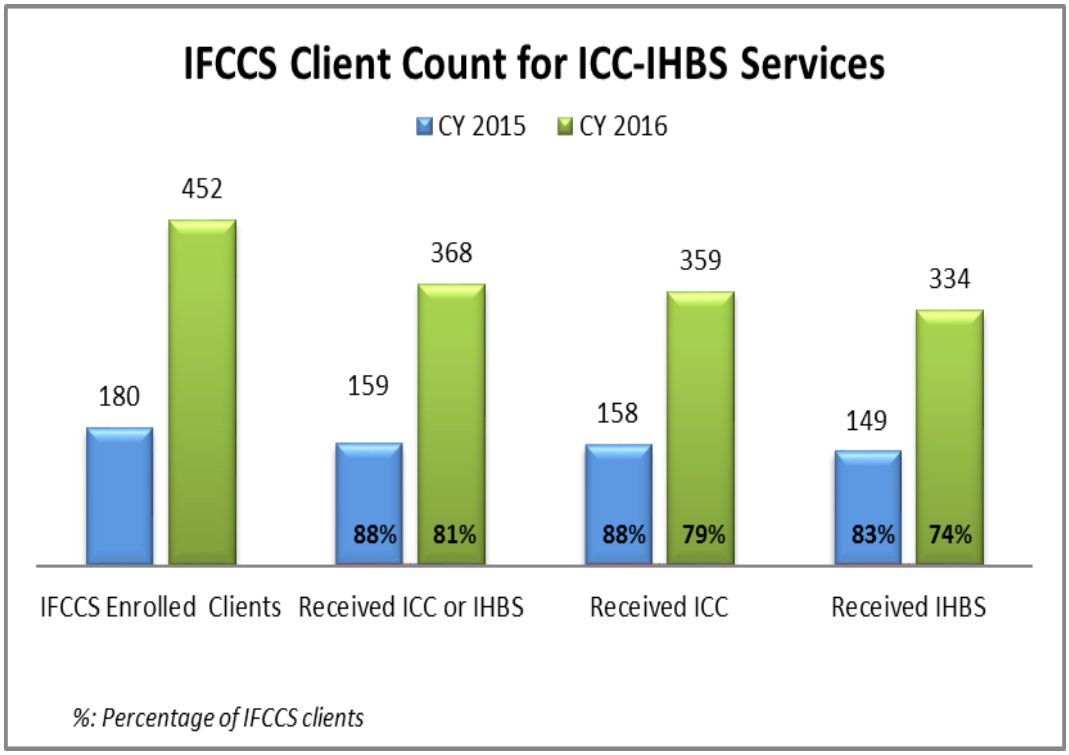
	Number of Clients Served (All Ages)			Number of Legal Entities (All Ages)			Number of Clients Served (Ages 0-5)			Number of Legal Entities (Ages 0-5)		
Evidence Based and Promising Practices	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2014**	**CY 2015**	**CY 2016**	**CY 2014**	**CY 2015**	**CY 2016**
Aggression Replacement Training (ART)	315	128	42	15	16	10	4	2	1	2	2	1
Alternatives for Families - Cognitive Behavioral Therapy (AF - CBT)	80	44	39	9	5	5	10	2	1	3	1	1
Brief Strategic Therapy	20	14	8	6	7	4	5	6	1	3	4	1
Child Parent Psychotherapy (CPP)	1,050	1,112	843	43	39	37	990	1,056	804	41	38	36
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	5	4	1	3	2	1	1	2	0	1	2	0
Functional Family Therapy (FFT)	143	114	100	11	10	9	5	9	37	2	3	2
Incredible Years (IY)	168	149	95	17	15	10	86	65	2	13	12	7
Managing and Adapting Practice (MAP)	2,693	2,684	2,163	84	84	72	397	466	37	60	52	52
Multisystemic Therapy (MST)	25	21	10	12	10	9	1	2	456	1	2	3
Parent-Child Interaction Therapy (PCIT)	421	517	534	36	42	42	352	437	3	35	39	41
Seeking Safety	1,107	706	393	61	62	44	20	7	483	5	6	2
Strengthening Families	21	5	3	2	1	1	1	0	3	1	0	0
Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)	3,277	2,917	2,160	84	77	72	488	417	326	54	46	48
Triple P Positive Parenting Program	310	266	184	35	29	26	138	120	119	28	21	20
UCLA Ties Transition Model	41	27	25	3	2	2	25	20	19	2	2	2

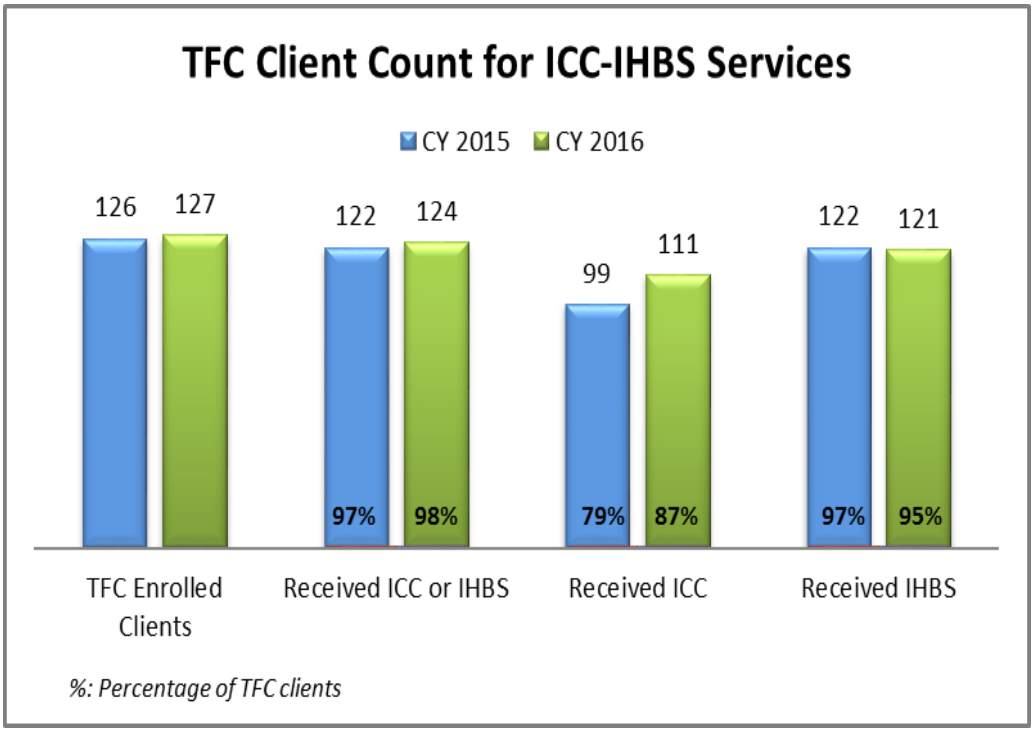
In December 2015 DMH shifted PEI dollars to expand Children's Field Capable Clinical Services (FCCS). This expansion allowed the Department to serve more children/youth and families who can benefit from intensive mental health services provided in the community. With this shift, there has been a decrease in PEI claiming and an increase in Child FCCS services which does not require a use of an EBP.

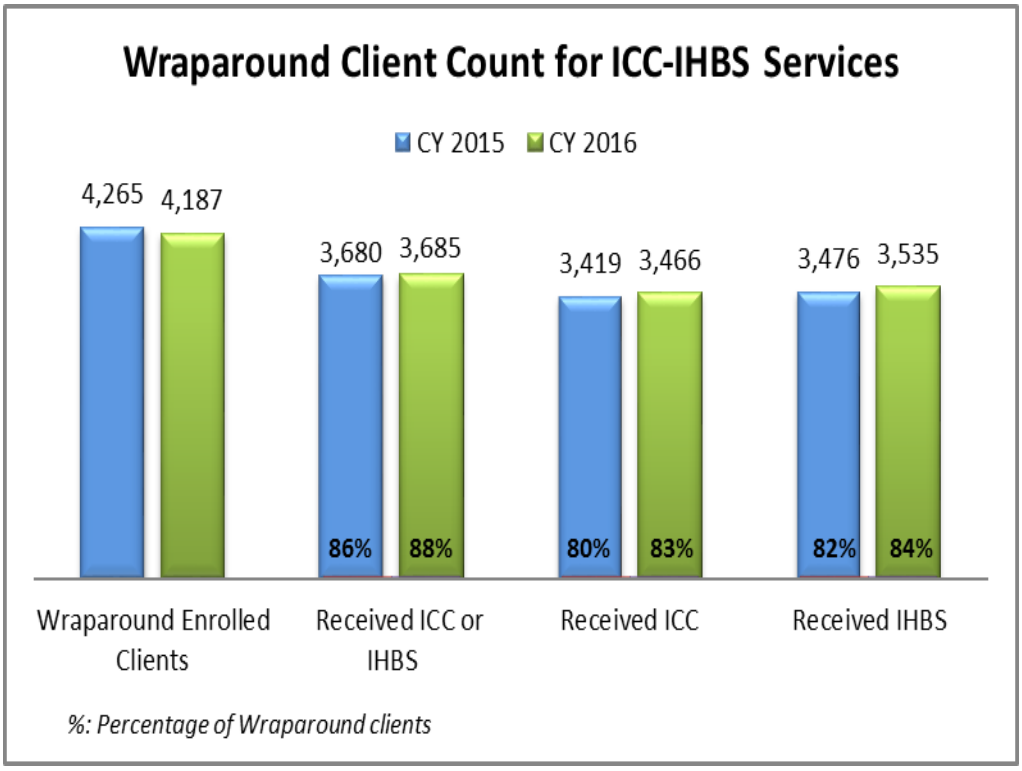
Intensive Home-Based Services and Intensive Care Coordination

The County has been phasing in ICC and IHBS since FY 12-13. As mentioned previously, DMH expanded IFCCS slots from 100 to 780 in CY 2016. FSP also had a change in FY 2015-16, with providers receiving a funding increase for 1/3 of child FSP slots to be used specifically for Katie A. subclass members. DMH expects to see an increase in ICC and IHBS services in CY 2017 for children and youth in these programs, as mental health providers become familiar with providing these services.

The graphs below show the number of clients within Intensive Field Capable Clinical Services (IFCCS), Treatment Foster Care (TFC), and Wraparound that have received ICC and IHBS during CY 2015 and CY 2016. The percentage of youth in Wraparound that received ICC and IHBS increased. There was a decrease in the number of youth that received these services in IFCCS. This may be due to the influx of clients through the IFCCS expansion and providers not yet being familiar with these services. Mental health providers are in the process of completing trainings to learn more about providing these services.







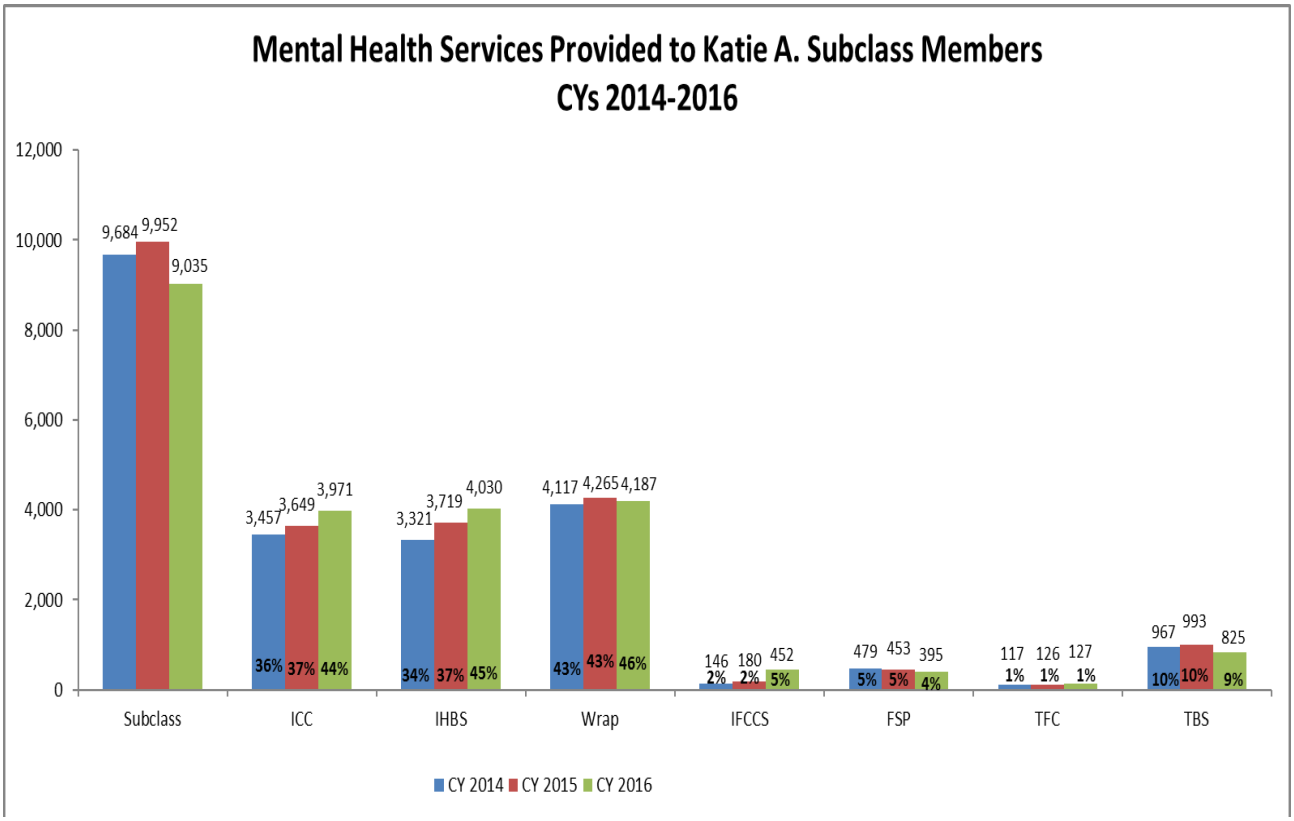
In response to the Panel's question, **"**Aren't all Wrap, FSP and IFCCS clients receiving IHBS by definition?" the following response is provided.

Clients in Wrap, FSP, and IFCCS may receive an array of services based on need in a variety of locations (i.e., home, school, etc.). IHBS is one of many services that clients in these programs may receive. Services provided in the home and other locations outside of the office setting may include IHBS, Individual and/or Family Therapy, ICC and more.

All of our providers have been instructed to claim ICC and IHBS services, as delivery of ICC and IHBS services are central to these models. DMH is currently investigating to see why they are all not claiming ICC and IHBS services at the level we might expect.

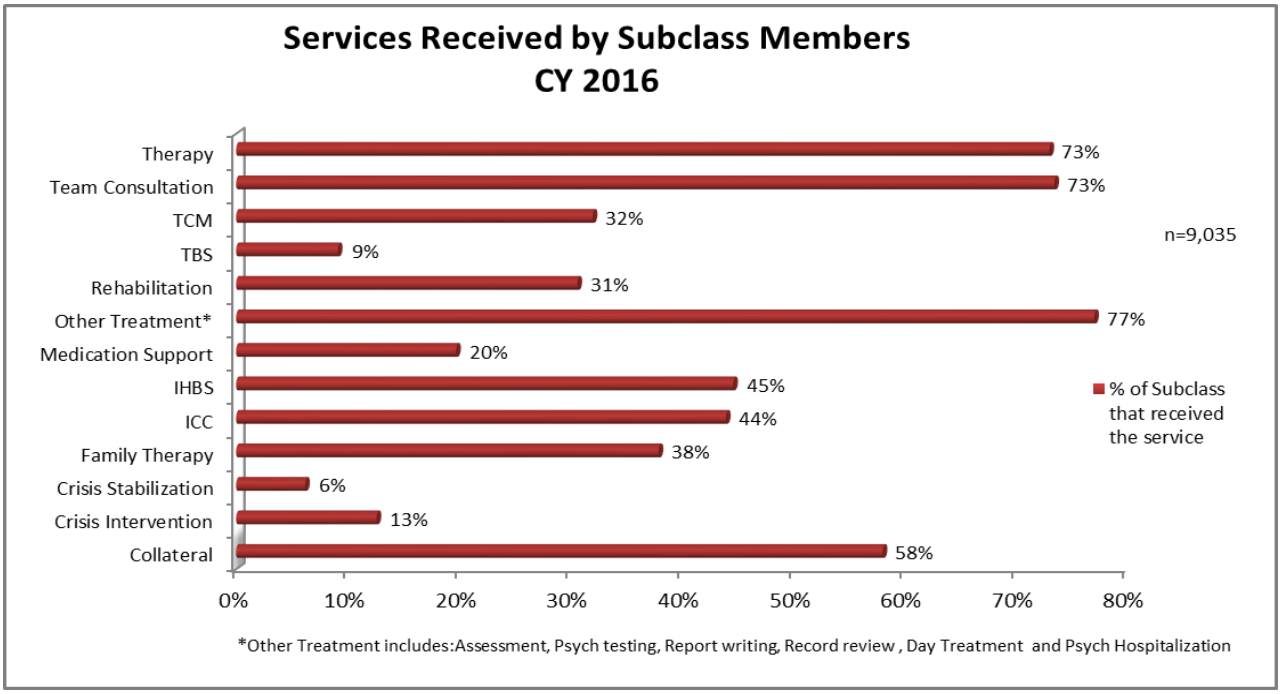
Mental Health Services Provided to Katie A. Subclass Members

The following graph provides a breakdown of the numbers and percentages of subclass members during calendar years 2014 to 2016 that have received ICC, IHBS, and other intensives services (Wraparound (Wrap), FSP, IFCCS, TFC, and TBS). The majority of subclass members received ICC, IHBS and Wraparound services in CY 2016. Some subclass members received more than one service and/or were enrolled in one or more programs during the calendar year.



The graph below indicates the types of mental health services subclass members received CY 2016. Some children/youth received more than one service. The percentage indicates that percent of subclass members that received the service.

The majority of clients received Other Treatment (77%), Therapy (73%), and Team Consultation (73%). IHBS and ICC services were also provided to 45% and 44% of subclass members, respectively.



Based on the previous data, there are a number of points that are worth highlighting:

1. The data show that the number of subclass members has decreased since CY 2014, making up a smaller percentage of the Katie A. Class. This may be partly due to the decrease in the number of youth that had three or more placements (as subclass indicator) within the last 24 months.

2. While the Subclass made up about 37% of the Class during CY 2016, the Subclass made up about 67% of the total Class cost.

3. The average mental health cost associated with Subclass Members has remained steady over the last three calendar years and is much higher than the average cost of mental health services for class members who are not part of the subclass.

4. In CY 2016, subclass members received less individual therapy than class members who are not part of the subclass. Subclass members did receive more targeted case management (TCM) including team consultation (TC) and ICC, and more rehabilitation services including TBS, collateral and IHBS than the class members who are not part of the subclass.

5. The data has been consistent and indicates that there are still more services being provided in the office for class members who are not part of the subclass (CY 2016: 32%) than for subclass members (CY 2016: 25%). Also, while DMH expected to see an increase in subclass members receiving more services in the home during calendar year 2016 than 2015, there was no change (CY 2015: 34%, CY 2016: 34%). Finally, while there does not seem to be a trend in more services provided in the home for subclass members than the class members who are not part of the subclass, subclass members do receive more services in alternate settings (group home, school, other facility) (CY 2016- Subclass: 33%, Class w/o subclass: 24%).

   In response to the questions raised by the Panel, "This is only a description of actuals not meeting expectations. Why was there no change in subclass home-based services provision? Are subclass members needs being met or not?" the following response is provided.

   DMH acknowledges that there are some limitations on the accuracy and comprehensiveness of this data: 1) This report does not fully reflect all class/subclass members and mental health services provided, as providers have 18

months to submit claims. 2) The transition of reporting out by calendar year vs. fiscal year has had an additional impact on the accuracy of the data and has resulted in only a partial view of mental health service provision in the County. DMH is working on alternative ways of gathering, analyzing and reporting out complete and accurate updates regarding service provision to class and subclass members.

6. Consistent with previous years, the majority of youth in the subclass had either three or more placements, were enrolled in Wraparound or were placed in a D-Rate home.

7. Within RCLs, the number of youth that received mental health services through DMH has remained steady in RCLs 10 and 12 while the percentage has decreased in RCLs 11, 13, and 14. It should be noted that less children/youth reside in RCL 13 when compared to the other RCLs (RCL 13- CY 2014: 12 residents, CY 2015: 10 residents, CY 2016: 7 residents).

   The number of class members that received an Evidence-Based Practice or Promising Practice has decreased since CY 2014 (CY 2014: 8,325; CY 2016: 6,164). In CY 2016, the majority of youth received Managing and Adapting Practice (MAP), Trauma Focused-Cognitive Behavioral Therapy (TF-CBT), Child Parent Psychotherapy (CPP) and Parent-Child Interaction Therapy (PCIT). In response to the Panel questions, "What were the expectations? Why did this result occur?" the following response is provided.

   In December 2015 DMH shifted PEI dollars to expand Children's Field Capable Clinical Services (FCCS). This expansion allowed the Department to serve more children/youth and families who can benefit from intensive mental health services provided in the community. With this shift, there has been an increase in Child FCCS services which does not require a use of an EBP or Promising Practice. This change actually increases the flexibility for providers to meet individual needs of children and families.

8. From CY 2015 to CY 2016, the percentage of youth that received ICC and IHBS in Wraparound increased, while only the percentage of youth who received ICC increased in TFC. Also, there was a decrease in the number of youth that received ICC and IHBS in IFCCS. DMH believes this is due to the influx of IFCCS clients in CY 2016 and providers not yet being familiar with billing for these services.

9. In CY 2016, the majority of subclass members received Other Treatment (77%), Therapy (73%), and Team Consultation (73%). IHBS and ICC services were also provided to 45% and 44% of subclass members, respectively.

Expansion of Home-Based Mental Health Services – Intensive Field Capable Clinical Services (IFCCS)

Intensive Field Capable Clinical Services (IFCCS) is a field based program developed in direct response to the State's expansion of services available to Katie A. Subclass members who have intensive mental health needs that are best met in a home-like setting. The goal of these services is to provide a coordinated child and family team approach to service delivery by engaging and assessing children and their families' strengths and underlying needs to minimize psychiatric hospitalizations, placement disruptions, out-of-home placements and involvement with the Juvenile Justice System.

DMH reports that on July 1, 2016, the IFCCS program expanded from five (5) Legal Entities to twenty one (21) Legal Entities and from one hundred (100) slots to seven hundred eighty (780) slots. The IFCCS referral portals were expanded from four (4) portals to twelve (12) portals. The IFCCS referral portals (referral sources) include the following:

Child and Youth Crisis Stabilization Team (funded by SB 82)	DCFS Transitional Shelter Care Facilities
DMH D-Rate Assessment Unit	DMH Emergency Outreach Bureau
DMH Hospital Discharge Unit	DMH MAT Staff
DMH Specialized Foster Care	DMH Wraparound Liaisons
IFCCS Providers	Medical HUBs
Service Area Child and TAY Navigators	Urgent Care Centers/Valley Coordinated

Referrals were received from the following referral portals in 2016:

DMH Specialized Foster Care – 30%
IFCCS Providers – 22%
DMH MAT Coordinators – 9%
DMH Hospital Discharge Unit – 8%
DCFS Emergency Shelter Care Facilities – 5%
DMH Child and TAY Navigators – 4%
Psychiatric Hospital Discharges – 4%
DCFS Transitional Shelter Care Facilities – 3%
Remaining Referral Portals- 15%

IFCCS program data from July 1, 2016, to February 15, 2017:

Number of Children/Youth Served	411
Average Weeks Served	10 Weeks
Average Services Per Week	2 Services
Top Five Services Provided	Intensive Care Coordination Intensive Home-Based Mental Health Services Team Plan Development Psychotherapy Psychiatric Diagnostic Evaluation

IFCCS Program Evaluation:

In 2016, Children's Systems of Care Administration (CSOC) created the Children's Intensive Service Review (CISR) to evaluate the IFCCS Program. The purpose of the evaluation process is to ensure IFCCS staff are adhering to the principles of the Shared Core Practice Model and consistently providing high quality mental health services to children and youth meeting the Katie A. Subclass criteria.

The CISR process will be conducted by teams of two or more reviewers and can include clinicians, administrators, and parent partners. Parent Partners will lead the interviews with the client's family in order to create an environment most conducive to candid and honest feedback. Cases representative of 20% served at the time of the review with six (6) months or more of service will be chosen. Each performance indicator will be evaluated separately to ensure a thorough assessment of each area.

By June 30, 2017, CSOC will complete nine (9) CISR evaluations.

The Panel asked, "How is CISR measuring responsiveness, intensity and child well-being outcomes? When will CISR achieve 20%? Will CISR be used for all IHBS cases (Wrap, FSP, IFCCS)?: The County response is as follows.

The entire CISR has been designed to measure responsiveness, intensity and child well-being outcomes. These elements are measured through chart review and client, family, formal and informal supports interviews.

DMH envisions using the CISR tool for all intensive programs that serve Katie A. Subclass children/youth.

While conducting the 10 CISR's during Fiscal Year 16-17, IFCCS Administration learned that the team can complete 20% CISR's over a two year period. Each CISR takes approximately 20 hours to complete a chart review, IFCCS team interview, separate client and family interviews, CSW interview, and other informal support interviews.

Coaching and Training of DCFS and DMH Staff in the Core Practice Model (SCPM)

DMH Training and Coaching Activities

The Child Welfare Division Coaches implemented the Shared Core Practice Model (SCPM), Child and Family Team (CFT) Model, & Underlying Needs training during the reporting period from January through December of 2016. In January of 2016 the DMH Coaches trained agencies participating in the Service Area (SA) 6 Immersion Pilot. These agencies included Drew Child Development Corporation, Southern California Health and Rehabilitation Program (SCHARP), Los Angeles Child Guidance Clinic (LACG), and Personal Involvement Center (PIC). The DMH Coaches provided intensive training and coaching on the Shared Core Practice Model (SCPM) and the Child and Family Teaming (CFT) process, and Underlying Needs. Each agency selected two children who met the Katie A. Subclass criteria. The agencies selected invited these children and their families to participate in the CFT training process. Additional Wraparound agencies that were trained in the SA 6 Immersion Area during the year 2016 included Vista Del Mar, Starview, Bayfront, Weber, and St. Anne's.

Agency staff were provided with an in-depth SCPM training with a major segment on Underlying Needs, as well as a series of CFT Modules: Module IA-Preparing for Child and Family Teaming, Module IB- Engaging Staff and Families in the Teaming Process, and Module II-Facilitating the Child and Family Team Meeting. These modules prepared agency staff to successfully facilitate the CFT process. In addition, agency staff were also provided with a Case Record Review Tools training which introduced the use of Genograms, Eco-Maps, and Timelines. The purpose of utilizing the Case Record Review tools was for CFT Facilitators to explore the impact of the natural support systems, family patterns, environmental factors, and significant life events on the children and families served by intensive mental health programs.

Mental health providers were provided with CFT Training Phase I and Phase II. During Phase I agency staff were developed as CFT Facilitators. This involved working with two families in order to implement the "see one, do one" training model. The staff being trained observed a DMH Coach facilitate a CFT Meeting, and then prepared to facilitate their own meeting with a different family. During Phase II agency staff were developed into CFT Coaches. The goal of Phase II was to develop a CFT Coach within each respective agency, who could train and develop CFT Facilitators within their agency. Part of Phase II included providing agency staff with CFT Module III, which is a training specifically tailored to develop and prepare CFT Coaches. CFT Module III was co-facilitated with DMH Coaches and Tricia Mosher Consultant, Alissa Kraman on April 19-20, 2016, and was provided to both DMH agency staff and DCFS staff.

Strengths-Needs Based Service Crafting Trainings

During this period, DMH and DCFS staff participated in trainings and curriculum development meetings with Marty Beyer on the topic of underlying needs, and Strengths-Needs Based Service Crafting. The purpose of these joint departmental meetings was to collaborate and brainstorm methods of effectively training our workforces including DMH contracted providers and DCFS staff. The trainings provided opportunities to develop consistent talking points, utilize vignettes to exemplify service crafting, and practice coaching techniques through the use of role-plays. Subsequent to these meetings, DMH was invited to observe a DCFS-led coaching workshop for DCFS staff on this topic.
Further, our CWD DMH Training Coordinator developed and presented a three-hour PowerPoint presentation on Strengths-Needs Based Service Crafting, which was presented to our DMH Immersion Providers and our DCFS partners on 10/19/16. This training was followed up by an intensive workshop by Marty Beyer on service crafting. During this training participants had the opportunity to brainstorm and develop specific tailored plans based on the strengths and underlying needs of clients in vignettes.

The Child and Family Teaming training sequence included various trainings and coaching activities. The entire training sequence is listed in Table 1.

Table 1.

SCPM-CFT Coaching & Training Sequence
Leadership and Implementation Meeting
6-HR Shared Core Practice Model Training
CFT Module IA-Introduction to Child and Family Teaming
CFT Module IB-Engaging Staff and Families in the Teaming Process
Case Record Review Tools Training-Using Genograms, Eco-Maps & Timelines
Case Exploration/Record Review
Staff Engagement
Child and Family Engagement
CFT Module II-Facilitating the Child and Family Team Meeting
CFT Module III-Coaching to SCPM Through Child and Family Teaming
CFT Meeting
CFT Debrief
Agency Debrief

The initial four agencies that participated in the Katie A. Immersion Pilot in SA 6 completed Phase I of the CFT training sequence from January through February of 2016. Agency staff from these mental health providers participated in multiple coaching and training activities during this period. Table 2 provides a list of the coaching and training activities that were delivered during that period.

Table 2.

Agency	Date	Training & Coaching Activity Phase I
DREW		
	1/06/16	CFT Module IA-Preparing for Child and Family Teaming
	1/12/16	CFT Module IA-Preparing for Child and Family Teaming
	1/13/16	CFT Module IB-Engaging Staff and Families
	1/13/16	Record Review Tools-Using Genograms, Eco-Maps & Timelines
LACG		
	1/06/16	CFT Module IA-Preparing for Child and Family Teaming
	1/12/16	CFT Module IA-Preparing for Child and Family Teaming
	1/13/16	CFT Module IB-Engaging Staff and Families
	1/13/16	Record Review Tools-Using Genograms, Eco-Maps & Timelines
PIC		
	1/06/16	CFT Module IA-Preparing for Child and Family Teaming
	1/12/16	CFT Module IA-Preparing for Child and Family Teaming
	1/13/16	CFT Module IB-Engaging Staff and Families
	1/13/16	Record Review Tools-Using Genograms, Eco-Maps & Timelines
SCHARP		
	1/06/16	CFT Module IA-Preparing for Child and Family Teaming
	1/12/16	CFT Module IA-Preparing for Child and Family Teaming
	1/13/16	CFT Module IB-Engaging Staff and Families
	1/13/16	Record Review Tools-Using Genograms, Eco-Maps & Timelines
	2/1/16 & 2/8/16	CFT Meetings

The DMH Coaches provided Phase II of the CFT training to Los Angeles Child Guidance Clinic, Drew Corporation, and Southern California Health and Rehabilitation Program. The CFT Facilitator at PIC had to pause her participation in the training process due to unexpected staffing changes at the agency, and therefore did not move

onto Phase II. However, the other agency staff providers continued and completed Phase II of the CFT training process.

Phase II consisted of developing the agency's CFT Facilitator into a CFT Coach. The CFT Coach would have the expertise needed to train and develop other staff into CFT Facilitators, thereby building internal capacity within the agency. Phase II involved working with four families in order to enable the "see one, do one" training method. The DMH Coach and the CFT Coach *Nominee* each worked with one respective family. The staff persons trained as a CFT Facilitators also worked with separate cases and each implemented the 4-Step CFT process independently with the assistance of their DMH Coach/CFT Coach Nominee. During this period, the DMH Coaches worked diligently to coordinate the multiple meetings involved in the CFT process for all the families. In addition, the CFT Coaches also provided the various module trainings to the provider staff at each of the agencies. The following table (Table 3.) lists the trainings and coaching activities provided to Los Angeles Child Guidance Clinic, Drew Corporation, and Southern California Health and Rehabilitation Program during Phase II.

Table 3.

Agency	Date	Coaching & Training Activity
LACG Phase II	5/12/16	CFT Module IA-Introduction to Child and Family Teaming
	5/12/16	CFT Module IB-Engaging Staff and Families in the Teaming Process
	5/16/16	Case Record Review Tools - Genograms, Eco-Maps & Timelines
	5/17/16	Case Exploration/Record Review
	5/19/16 5/23/16	Staff Engagement
	5/23/16 5/24/16 6/14/16	Child and Family Engagement
	6/10/16	CFT Module II-Facilitating the Child and Family Team Meeting
	6/13/16 6/28/16 6/29/16	CFT Meetings
	6/15/16 7/6/16 7/7/16	CFT Debriefs
	8/22/16	Agency Debrief
DREW Phase II	4/27/16	CFT Module IA-Introduction to Child and Family Teaming
	4/29/16	CFT Module IB-Engaging Staff and Families in the Teaming Process
	5/6/16	Case Record Review Tools - Genograms, Eco-Maps & Timelines
	5/6/16 5/10/16	Case Exploration/Record Review
	5/11/16 5/13/16 5/17/16	Staff Engagement
	5/12/16 5/17/16 5/24/16	Child and Family Engagement
	6/1/16	CFT Module II-Facilitating the Child and Family Team Meeting
	6/7/16 6/9/16 6/14/16	CFT Meeting
	6/17/16 6/20/16 6/21/16	CFT Debrief
SCHARP Phase II	5/9/16	CFT Module IB-Engaging Staff and Families in the Teaming Process
	5/9/16	Case Record Review Tools - Genograms, Eco-Maps & Timelines
	5/10/16	Case Exploration/Record Review
	5/10/16	Staff Engagement

Agency	Date	Coaching & Training Activity
	5/11/16 5/13/16	Child and Family Engagement
	5/9/16	CFT Module II-Facilitating the Child and Family Team Meeting
	5/25/16 5/26/16	CFT Meeting
	5/27/16	CFT Debrief

Upon completing work with these agencies, the DMH Coaches continued to work with additional agencies in SA 6. These agencies included Bayfront, and Vista Del Mar, and Starview. The following table (Table 4.) lists the trainings and coaching activities provided to these agencies.

Table 4.

Agency	Date	Coaching & Training Activity
Bayfront Phase I	6/21/16	Leadership and Implementation Meeting
	7/11/16	CFT Module IA-Introduction to Child and Family Teaming
	7/12/16	CFT Module IB-Engaging Staff and Families in the Teaming Process
	7/18/16	Case Record Review Tools - Genograms, Eco-Maps & Timelines
	7/18/16	Case Exploration/Record Review
	7/19/16	Staff Engagement
	8/9/16	Child and Family Engagement
	8/1/16	CFT Module II-Facilitating the Child and Family Team Meeting
	8/11/16	CFT Meeting
Bayfront	9/26/16	Case Exploration/Record Review
	10/17/16	Staff Engagement
	10/17/16	Child and Family Engagement
	10/24/16	CFT Meeting
	10/26/16 11/8/16	CFT Debrief Agency Debrief
Vista Del Mar Phase I	5/12/16	Leadership and Implementation Meeting
	5/25/16	CFT Module IA-Introduction to Child and Family Teaming
	6/1/16	CFT Module IB-Engaging Staff and Families in the Teaming Process
	6/1/16 6/9/16	Case Record Review Tools - Genograms, Eco-Maps & Timelines
	6/1/16	Case Exploration/Record Review
	6/7/16 6/13/16	Staff Engagement
	6/10/16 6/13/16 6/20/16 6/23/16	Child and Family Engagements
	6/24/16	CFT Module II-Facilitating the Child and Family Team Meeting
	6/28/16 7/7/16	CFT Meeting
	7/12/16	CFT Debrief
Phase II	8/15/16	CFT Module IA-Introduction to Child and Family Teaming
	8/15/16	CFT Module IB-Engaging Staff and Families in the Teaming Process
	8/23/16	Case Record Review Tools - Genograms, Eco-Maps & Timelines
	9/1/16	Case Exploration/Record Review
	9/6/16	Staff Engagement
	9/8/16 9/12/16 9/13/16	Child and Family Engagements

	9/19/16 9/21/16	
	9/12/16	CFT Module II-Facilitating the Child and Family Team Meeting
	9/19/16 9/21/16 9/27/16	CFT Meeting
	9/26/16 10/27/16	CFT Debrief Agency Debrief
Starview Phase I	8/8/16	CFT Module IA-Introduction to Child and Family Teaming
	8/9/16	CFT Module IB-Engaging Staff and Families in the Teaming Process
	8/11/16	Case Record Review Tools - Genograms, Eco-Maps & Timelines
	8/11/16	Case Exploration/Record Review
	8/11/16 8/18/16	Staff Engagement
	8/15/16	Child and Family Engagement
	8/18/16	CFT Module II-Facilitating the Child and Family Team Meeting
	8/25/16 8/29/16	CFT Meetings
	8/30/16	CFT Debriefs
Phase II	10/7/16 10/11/16	CFT Module IA-Introduction to Child and Family Teaming
	10/12/16	CFT Module IB-Engaging Staff and Families in the Teaming Process
	10/12/16	Case Record Review Tools - Genograms, Eco-Maps & Timelines
	10/12/16	Case Exploration/Record Review
	10/13/16	Staff Engagement
	10/18/16 10/20/16	Child and Family Engagement
	10/24/16	CFT Module II-Facilitating the Child and Family Team Meeting
	10/27/16 11/01/16 11/07/16	CFT Meeting
	10/27/16 11/01/16 11/07/16 11/08/16	CFT Debrief

The next two agencies to participate in the SCPM, CFT, and Underlying Needs training process in SA 6 were Special Services for Groups (SSG)-Weber and St. Anne's. The agencies participated in the Leadership and Implementation Meeting and identified staff that would be developed into CFT Facilitators. Both agencies completed Phase I of the CFT process in December of 2016. The following tables list the trainings and coaching activities provided to these agencies. The following tables list the coaching and training activities that took place during this period at St. Anne's and at SSG-Weber.

Table 5.

St. Anne's Trainings	**Date**
Leadership and Implementation	10/27/16
Module IA	11/14/16
Module IB	11/14/16
Module II	11/21/16
Training Tools	11/15/16
Case Reviews	11/16/16
Staff Engagements	11/16/16
Family Engagements	11/17/16 & 12/01/16

CFT Meetings	11/30/16 & 12/14/16
Debrief Meetings	12/16/16
SCPM-6Hrs.	12/12/16
Agency Debrief Meeting	1/13/17

Table 6.

Learning Collaborative

DMH District Chief Yolanda Whittington held monthly Learning Collaborative meetings for the Service Area 6 Immersion Provider agencies. Participants also included the DMH Coaches and DCFS Compton Office leadership staff including the Service Linkage Specialist, ARAs, and the RA. These meetings were held on the following dates: 3/29/16, 4/19/16, 5/31/16, 6/28/16, 7/26/16, 9/27/16, 10/25/16, and 11/29/16. The DMH Coaches and leadership staff from the DCFS Compton Office continued to attend these meetings. The topics that were discussed included case documentation, case presentations, and brainstorming sessions about interventions. During these sessions, there was a clear connection made between the clinical assessment, treatment plan, and the Child and Family Teaming process, and underlying needs specifically the CFT Matrix. The DMH Coaches have brainstormed on creating a tool that can be used by Wraparound providers to link information from the CFT Matrix to the DMH clinical assessment and treatment plan. This may better assist Wraparound providers in identifying needs and utilizing the CFT Matrix when they are developing their treatment goals and completing their assessments. The DMH Coaches will be working with Yolanda Whittington to make this a topic of discussion at the upcoming

Special Services for Groups-Weber Trainings	**Date**
Leadership and Implementation	11/01/16
Module IA	11/14/16
Module IB	11/14/16
Module II	11/28/16
Training Tools	11/16/16
Case Reviews	11/16/16
Staff Engagements	11/16/16
Family Engagements	11/29/16 & 12/01/16
CFT Meetings	12/07/16 & 12/08/16
Debrief Meetings	12/07/16 & 12/08/16 & 12/12/16
Agency Debrief Meeting	1/11/17

Learning Collaborative meetings. Please

The Panel asked for a definition of the matrix, which is as follows. During these sessions, the DMH Coaches identified the connection between the clinical assessment, treatment plan, Plan of Care and the Child and Family Teaming process—more specifically the DMH Child and Family Team Planning Matrix, which is a tool used during the CFT Meeting to document the child and family's plan.

Post CFT Interviews:

The Community Worker assigned to the Coaching unit continued to conduct Post CFT interviews with the children, parents, and caregivers that have participated in the CFT process during the course of the CFT Training at each respective agency. Children and families provided feedback about their experiences during the formation of their Child and Family Teaming process. The purpose of these interviews was been to learn what has worked well, and what needs to be improved during the process. The Post CFT Interviews continued to consist of in-person, or over the phone interviews. The interviews were conducted approximately one week after the CFT meeting has taken place.

SA 6 Immersion Provider Meetings:

The DMH Coaches hosted SA 6 Immersion Provider Meetings during this period with staff from all four Immersion Pilot agencies and the DMH Coaches. The initial meeting was held on 5/3/16. During this meeting, results from the Post CFT Interviews were shared with the providers. There were discussion on the strengths and challenges of the CFT process, the unexpected outcomes, and the plan for incorporating the CFT Process into future service delivery. The SA 6 Provider staff reported that they found this meeting helpful in reviewing the benefits and lessons learned during the CFT training process.

The DMH Coaches organized a second SA 6 Immersion Provider Meeting for the provider staff on 8/17/16. This meeting focused on presenting additional results from the Post CFT Interviews, and discussing the agency's integration of the of the CFT process into current service delivery. There was also a presentation and skill building activity on developing effective "worry" statements, as a means of building a stronger engagement with children, youth, and families.

Training and Coaching in Immersion SA 3 & 7:

Implementation of the SCPM-CFT training in Immersion Service Areas 3 and SA 7 began in October 2016. The DMH Coaches delivered the 6 HR trainings to 22 Specialized Foster Care staff in SA 3 on 10/18/16 and to 25 Specialized Foster Care staff in SA 7 on 10/25/16. The next group that was trained in SA 3 and SA 7 was the MAT Assessors. Trainings were delivered to MAT in SA 3 on 11/15/16 and to SA 7 on 11/29/16. Tables 7 and 8 list the training dates and number of participants that participated in each specific training during the reporting period up until 2016.

Table 7.

SA 3 Trainings	**Date**	**Program**	**Number of Participants**
6 HR SCPM	10/18/16	SFC	22
6 HR SCPM	11/15/16	MAT	16

Table 8.

SA 7 Trainings	**Date**	**Program**	**Number of Participants**
6 HR SCPM	10/25/16	SFC	15
6 HR SCPM	11/29/16	MAT	49

The training plan for Immersion SA 3 and 7 includes training staff from the Wraparound agencies. Participants will included staff from the Wraparound teams including the Wraparound Facilitator, Child Family Specialist, Parent Partner, and Therapist. These groups will begin by attending the *6-HR SCPM* training and the *CFT Module IA* (Preparing for Child and Family Teaming) training. Facilitators from these Wraparound teams will then be required to participate in a 2 Day CFT Facilitator Training which will provide an in-depth training on the tenets of the CFT process and the specific facilitation skills that are required to implement an effective teaming process with children and families. Upon completion of the 2-Day CFT Facilitator Training, the DMH Coaches will offer intensive coaching and consultation to the trained Facilitators as they implement the SCPM, CFT, and Underlying Needs training process with children that are identified for the Immersion Pilot.

Training	**Date of Training**	**Trained by**	**Participants included:**
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	7/19/16	Jessica Walters, PhD	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	7/25/16	DMH Coaches	DMH Staff and Children's Providers Countywide

Training	Date of Training	Trained by	Participants included:
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	8/10/16	Jessica Walters, PhD	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	8/18/16	DMH Coaches	DMH Staff and Children's Providers Countywide
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	9/13/16	Jessica Walters, PhD	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	9/21/16	DMH Coaches	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	9/23/16	DMH Coaches	Aviva
Trauma Informed Practice	9/29/16	Jeanette Yoffe, MFT	DMH Staff and Children's Wraparound; IFCCS; TFC; and FSP providers Countywide
Shared Core Practice Model	9/30/16	DMH Coaches	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	10/11/16	DMH Coaches	DMH Staff and Children's Providers Countywide
Shared Core Practice Model	10/12/16	DMH CWD Staff	Enki
Shared Core Practice Model	10/14/16	DMH CWD Staff	Children's Institute Inc.
Shared Core Practice Model with an Emphasis on Underlying Needs	10/18/16	DMH Coaches	SA 3 DMH Specialized Foster Care and Administration Staff
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	10/19/16	Jessica Walters, PhD	DMH Staff and Children's Providers Countywide
Shared Core Practice Model with an Emphasis on Underlying Needs	10/25/16	DMH Coaches	SA 7 DMH Specialized Foster Care and Administration Staff
Trauma Informed Practice	10/27/16	Jeanette Yoffe, MFT	DMH Staff and Children's Wraparound; IFCCS; TFC; and FSP providers Countywide
Shared Core Practice Model	11/9/16	DMH CWD Staff	Aviva
Shared Core Practice Model	11/10/16	DMH CWD Staff	Guidance Center Family Preservation Services
Shared Core Practice Model with an Emphasis on Underlying Needs	11/15/16	DMH Coaches	SA 3 MAT Assessors
Trauma Informed Practice	11/17/16	Jeanette Yoffe, MFT	DMH Staff and Children's Wraparound; IFCCS; TFC; and FSP providers Countywide

Training	Date of Training	Trained by	Participants included:
Shared Core Practice Model	11/17/16	DMH Coaches	DMH Staff and Children's Providers Countywide
Infant and Toddler Development within a Relational Context	11/17/16	Mike Sherman, PsyD	DMH Staff and Children's Providers Countywide
Infant and Toddler Development within a Relational Context	11/21/16	Mike Sherman, PsyD	SA 1 Children's Providers
Shared Core Practice Model with an Emphasis on Underlying Needs	11/29/16	DMH Coaches	SA 7 MAT Assessors
Core Practice Concepts in Working with LGBTQ Youth	12/8/16	Al Killen-Harvey, LCSW	DMH Staff and Children's Providers Countywide
Shared Core Practice Model with an Emphasis on Underlying Needs	12/12/16	DMH Coaches	
Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)	12/14/16	Jessica Walters, PhD	DMH Staff and Children's Providers Countywide
Trauma Informed Practice	12/15/16	Jeanette Yoffe, MFT	DMH Staff and Children's Wraparound; IFCCS; TFC; and FSP providers Countywide
Shared Core Practice Model	12/15/16	DMH Coaches	DMH Staff and Children's Providers Countywide
Shared Core Practice Model with an Emphasis on Underlying Needs	1/12/17	DMH Coaches	SA 7 Children's Wraparound Providers
Shared Core Practice Model	1/12/17	DMH CWD Staff	Pathways Community Services
Shared Core Practice Model	1/17/17	DMH CWD Staff	DMH Staff and Children's Providers Countywide
Infant and Toddler Development within a Relational Context	1/17/17	Mike Sherman, PsyD	The Village Family Services
Shared Core Practice Model with an Emphasis on Underlying Needs	1/19/17	DMH Coaches	SA 3 Children's Wraparound Providers
Core Practice Concepts in Working with LGBTQ Youth	1/25/17	Al Killen-Harvey, LCSW	DMH Staff and Children's Providers Countywide
Infant and Toddler Development within a Relational Context	1/25/17	Mike Sherman, PsyD	The Village Family Services
Infant and Toddler Development within a Relational Context	1/26/17	Mike Sherman, PsyD	The Village Family Services
Shared Core Practice Model with an Emphasis on Underlying Needs	1/26/17	DMH Coaches	SA 7 Children's Wraparound Providers

Training	Date of Training	Trained by	Participants included:
Trauma Informed Practice	1/26/17	Jeanette Yoffe, MFT	DMH Staff and Children's Wraparound; IFCCS; TFC; and FSP providers Countywide
Infant and Toddler Development within a Relational Context	1/27/17	Mike Sherman, PsyD	LA+USC VIP CMHC
Shared Core Practice Model with an Emphasis on Underlying Needs	2/2/17	DMH Coaches	SA 7 Children's Wraparound Providers
Shared Core Practice Model with an Emphasis on Underlying Needs	2/7/17	DMH Coaches	SA 3 Children's Wraparound Providers
Shared Core Practice Model with an Emphasis on Underlying Needs	2/9/17	DMH Coaches	SA 7 Children's Wraparound Providers
Infant and Toddler Development within a Relational Context	2/15/17	Mike Sherman, PsyD	SA 7 MAT Assessors
Trauma Informed Practice	2/16/17	Jeanette Yoffe, MFT	DMH Staff and Children's Wraparound; IFCCS; TFC; and FSP providers Countywide
Shared Core Practice Model	2/16/17	DMH CWD Staff	DMH Countywide Resource Services staff
Shared Core Practice Model	2/17/17	DMH CWD Staff	El Centro De Amistad
Infant and Toddler Development within a Relational Context	2/22/17	Mike Sherman, PsyD	DMH Children's System of Care
Culturally Sensitive Practice: Integration of Core Practice Concepts	2/23/17	Barbara Stroud, PhD	DMH Staff and Children's Providers Countywide

SCPM and CFT Meeting Trainings

DMH Children's System of Care (CSOC) Administration launched a five (5) month, community-based Child and Family Team meeting training program in all of the Supervisorial Districts and in all eight (8) Service Areas (SA). The training targeted intensive mental health programs funded under the Mental Health Services Act (MHSA) Community Support Services (CSS) plan. It specifically targeted directly contracted Child Full Service Partnership (FSP) and Intensive Field Capable Clinical Services (IFCCS) Program Supervisors and seasoned clinical staff who provide services to child welfare involved children, and who are candidates to facilitate Child and Family Team (CFT) meetings. A total of one hundred (119) staff were trained over the five (5) month period. This five (5) month training was intended to lay the foundation of the Shared Core Practice Model (SCPM), and enhanced the participants' ability to work collaboratively on difficult cases and provide an opportunity to develop skills in facilitating CFT meetings. Based on enhanced collaboration, it was anticipated that communication among service providers from different disciplines will lead to improved outcomes for the families of children and TAY from traditionally underserved communities. Additionally, it is hoped that the training will lead to improved "teaming" scores for the Quality Service Reviews (QSR), a priority for both DMH and DCFS.

Intensive Care Coordination and Intensive Home Based Services Trainings:

Date	Agency Name	Program Type	Number Trained
June 23, 2016	Child & Family Guidance Center	FSP	1
	Children's Institute	FSP/IFCCS	4
	Community Family Guidance Center	FSP	2
	David & Margaret	FSP	1
	Drew Child Development Corporation	FSP	1
	Foothill Family	FSP/IFCCS	2
	Hathaway-Sycamores	FSP/IFCCS	3
	Hillsides	FSP	2
	Kedren	FSP	2
	Pacific Clinics	FSP	1
	Pathways Community Services	FSP	1
	Special Services for Groups –APTC	FSP/IFCCS	2
	The Guidance Center	TSP	1
	Uplift	FSP/IFCCS	2
February 3, 2016	Alma Family	IFCCS/FSP	2
	Almansor Center	FSP	1
	American Indian Counseling Center	FSP	1
	Asian Pacific Counseling & Treatment Centers	FSP	3
	Child & Family Guidance Center	FSP	3
	Children's Institute	FSP/IFCCS	2
	Community Family Guidance Center	FSP	2
	David & Margaret	FSP	1
	Enki	FSP	2
	Harbor View CSC	FSP	2
	Hathaway-Sycamores	FSP/IFCCS	4
	Hillsides	FSP	1
	Kedren	FSP	3
	Los Angeles Child Guidance Clinic	FSP/IFCCS	2
	Masada Homes	FSP/IFCCS	2
	Optimist Mental Health	FSP	2
	Pacific Clinics	FSP	5
	Pacific Asian Counseling Services	FSP	3
	Pathways Community Services	FSP	1
	Roybal Family	FSP	2

	Saint Anne's	FSP	2
	San Fernando Valley Mental Health Center	FSP	2
	Special Service for Groups - APCTC, OTTP, & Weber	FSP/IFCCS	3
	Star View Community	FSP/IFCCS	1
	Tessie Cleveland	FSP	4
	The Guidance Center	FSP	4
	The Help Group	FSP	5
	Uplift	FSP/IFCCS	1

DCFS Training and Coaching Activities

The SCPM team has been working with Dr. Beyer, Katie A. Panel member, since April 2016, with a more recent concentrated focus on **Strengths Needs Service Crafting** (SNSC).

Over the last year, the SCPM team has focused on the following:
1. Operationalizing SCPM using implementation science; and
2. Skills development of staff through several supportive modalities that are anchored in SNSC.

In August 2016, a team was identified to develop a SNSC Curriculum. The team includes both DCFS and DMH staff. This allows for the co-creation of curriculum that is responsive to the needs of various partners and child welfare professionals, and is consistent with the strategy shared at the November 2016 Panel meeting.

The team, in partnership with Dr. Beyer, convened several focus groups including:

- ER/DI SCSWs
- ER/CS SCSWs
- Coaching skills groups
- Coaching Roundtable team
- DMH community providers
- Immersion offices
- New hire Academy group

These learning opportunities not only exposed staff to SNSC practice but served as teachable moments for staff, opportunities to deepen understanding and practice, for the transfer of learning and to provide support through coaching.

This was also a first look to inform possible teaching strategies, as these small concentrated teams allowed for practice and feedback. The group served as foundation to the SNSC work.

Currently, the team is reviewing curriculum for vetting and developing a training and coaching rollout plan. The vision is to train and coach on one day and to support staff at the unit level through this well-developed rollout strategy.

In addition, the following are being developed in SCPM to support this work and learning across the system:

- Coaching Infrastructure to support practice - this involves hiring strategies to include role play in the interview that highlights characteristics that support coaching, teamwork and engagement skills, leadership and facilitation skills. This approach was adapted by Humboldt County and is currently used in San Bernardino County.

- Coaching Roundtable to support SCPM operationalization and skill building - SNSC was introduced to this group by Dr. Beyer in April 2016. As a result, the SCPM team has continued to build on this work. This group is attended by Coach Developers across

the county. The county wide coaching team develops agendas that include workshops and coaching interventions and strategies that support practice, including listening strategies, coaching practices, certification practice and learning, understanding culture, rigorous and balanced assessments and other practice opportunities to support the regional Coach Developers so they can take information to their office and embed in their daily practice. This work builds capacity across the system.

The curriculum developed will be used by both the DCFS Training and Coaching teams to:

- Deepen understanding of strengths/needs-based practice;
- Build skills to identify trauma-related and developmental needs; and
- Build confidence in crafting unique services to meet each child's needs and supporting for his/her caregiver and family to meet those needs.

The Panel asked, "Can you link these references to Service Areas to the associated Immersion office?" The County response is as follows.

Margins

The Child Welfare Division Coaches implemented the Shared Core Practice Model (SCPM), Child and Family Team (CFT) Model, & Underlying Needs training during the reporting period from January through December of 2016. In January of 2016 the DMH Coaches and consultants from Tricia Mosher Consulting trained agencies participating in the Service Area (SA) 2 and SA 6 Immersion Pilot. The agencies in SA 2 included The Village Family Services, Pennylane, Hathaway-Sycamore and San Fernando Community Mental Health Center. The agencies in SA 6 included Drew Child Development Corporation, Southern California Health and Rehabilitation Program (SCHARP), Los Angeles Child Guidance Clinic (LACG), and Personal Involvement Center (PIC). In addition, five Wraparound agencies from SA 6, Vista Del Mar, Starview, Bayfront, Weber, and St. Anne's, were also trained. The DMH Coaches and consultants provided intensive training and coaching on the Shared Core Practice Model (SCPM), the Child and Family Teaming (CFT) process, and Underlying Needs: A Strengths/Needs-Based Service Crafting Approach. Each agency selected two children who met the Katie A. Subclass criteria and who were receiving services from either the Compton DCFS Office or the Van Nuys DCFS Office. The agencies selected invited these children and their families to participate in the CFT process.

In SA 6, agency staff were provided with an in-depth SCPM training with a major segment on Underlying Needs, as well as a series of CFT Modules: Module IA-Preparing for Child and Family Teaming, Module IB- Engaging Staff and Families in the Teaming Process, and Module II-Facilitating the Child and Family Team Meeting. These modules prepared agency staff to successfully facilitate the CFT process. In addition, agency staff were provided with a Case Record Review Tools training which introduced the use of Genograms, Ecomap, and Timelines. The purpose of utilizing the Case Record Review tools was for CFT Facilitators to explore the impact of the natural support systems, family patterns, environmental factors, and significant life events on the children and families served by intensive mental health programs.

Mental health providers were provided with CFT Training Phase I and Phase II. During Phase I agency staff were developed as CFT Facilitators. In order to implement the "see one, do one" CFT training model, this involved the Coach and Facilitator working with two children and their families. The staff being trained observed a DMH Coach facilitate a CFT Meeting, and then prepared to facilitate their own meeting with a different family. During Phase II agency staff were developed into CFT Coaches. The goal of Phase II was to develop a CFT Coach within each respective agency, who could train and develop CFT Facilitators within their agency. Part of Phase II included providing agency staff with CFT Module III, which is a training specifically tailored to develop and prepare CFT Coaches. CFT Module III was co-facilitated with DMH Coaches and Tricia Mosher Consultant, Alissa Kraman, on April 19-20, 2016, and was provided to both DMH agency staff and DCFS staff.

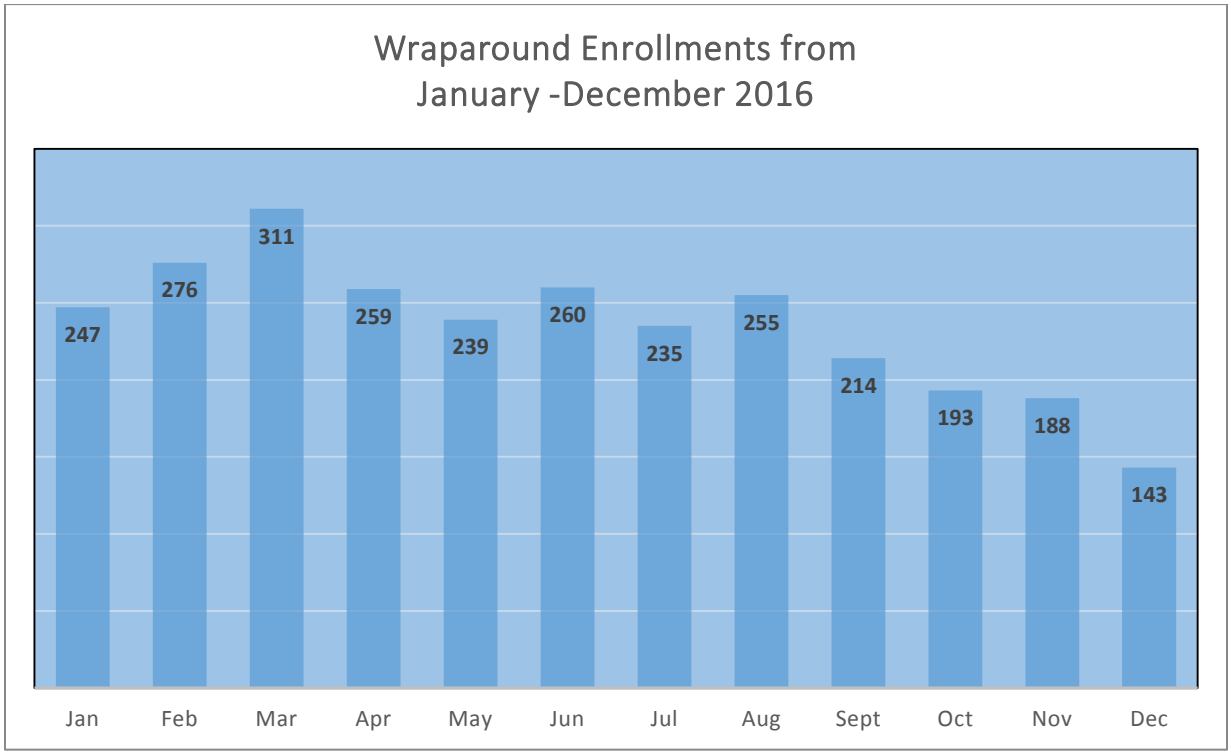
Wraparound Services

As was reported in a prior Panel report, DMH, at the direction of the Board of Supervisors, DMH is taking over management of the Wraparound Program from DCFS no later than June 30, 2016. The Department of Mental Health reports the following about the status of that transition.

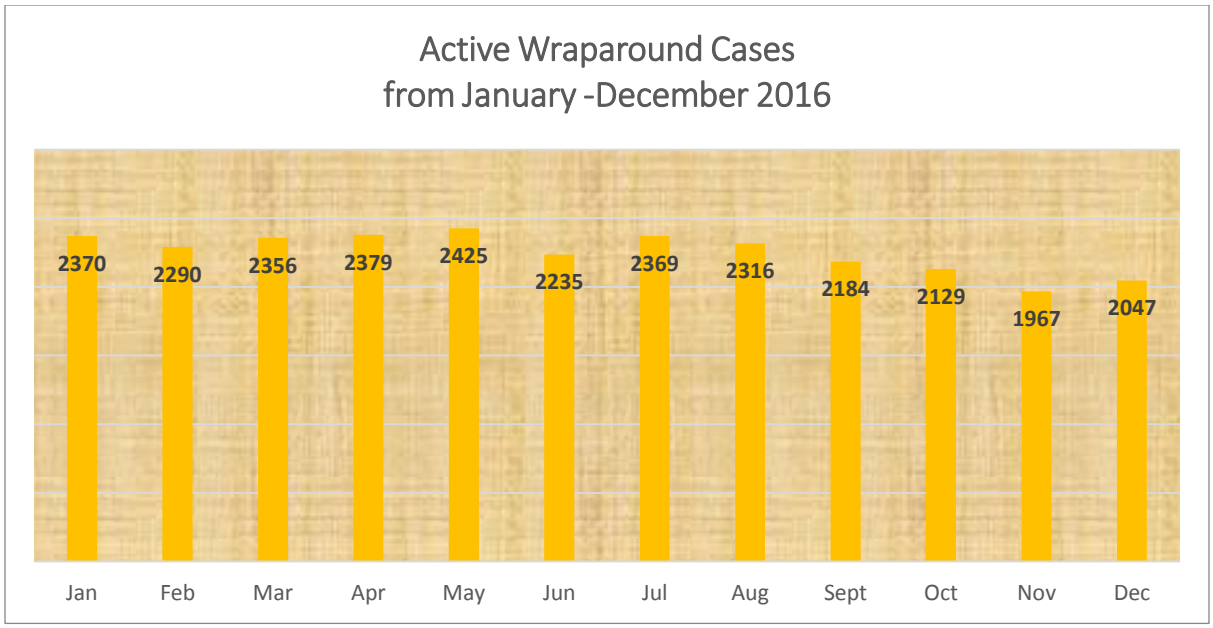
County Update

The two agencies continue working on a transition plan to address key components of system operations. There are 48 Wraparound service providers, which DMH refers to as legal entities, at 64 sites throughout the County. The new Wraparound contract replaced the former two-tier system with one Case Rate/Medi-Cal payment. According to DMH, one of the advantages of this payment structure is the financial feasibility of providers being able to serve children in residential facilities (with no identified caregiver), as they no longer are required to deduct the placement cost. DMH believes that the new approach enhances and highlights the Mental Health and Intensive Care Coordination/Intensive Home-Based Services (ICC/IHBS) mandated by the State's settlement of the Katie A. lawsuit that is inclusive of the Shared Core Practice Model.

From January through December, 2016, a total of 2,820 children/youth were enrolled in Wraparound. The following table shows monthly enrollments.



Data Source-DCFS Wraparound System -2/23/2017



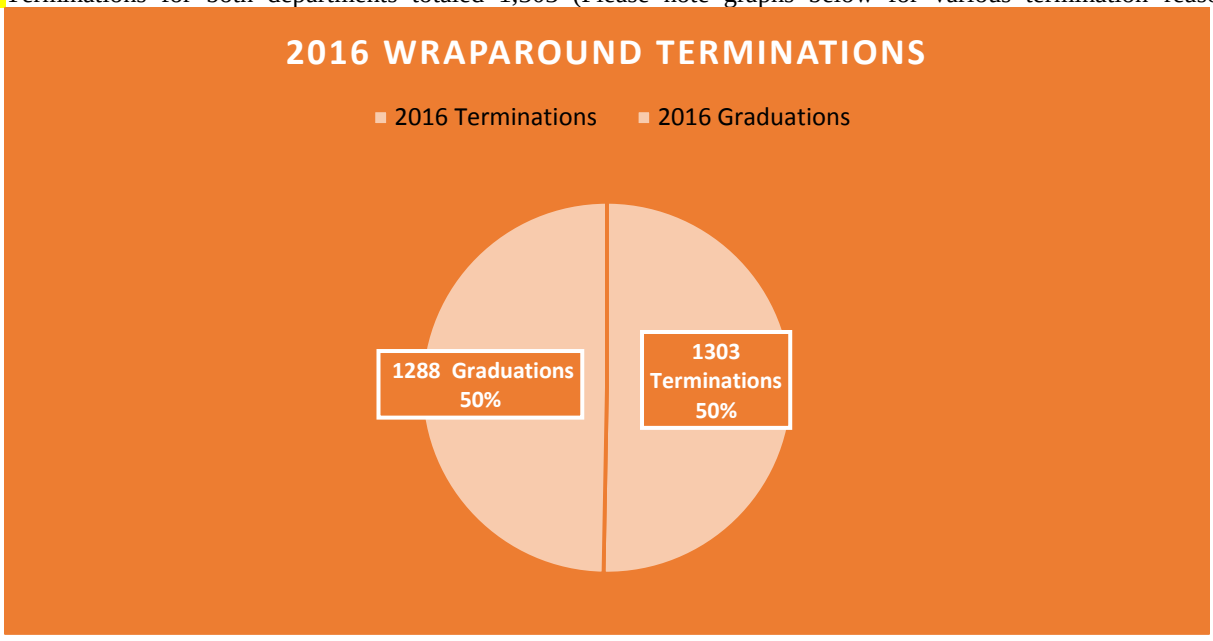
Data Source-DCFS Wraparound System -2/23/2017

From January through December, 2016, there was an average of 2,256 monthly active Wraparound cases:

Wraparound Graduations, Neutral Terminations and Terminations by Category

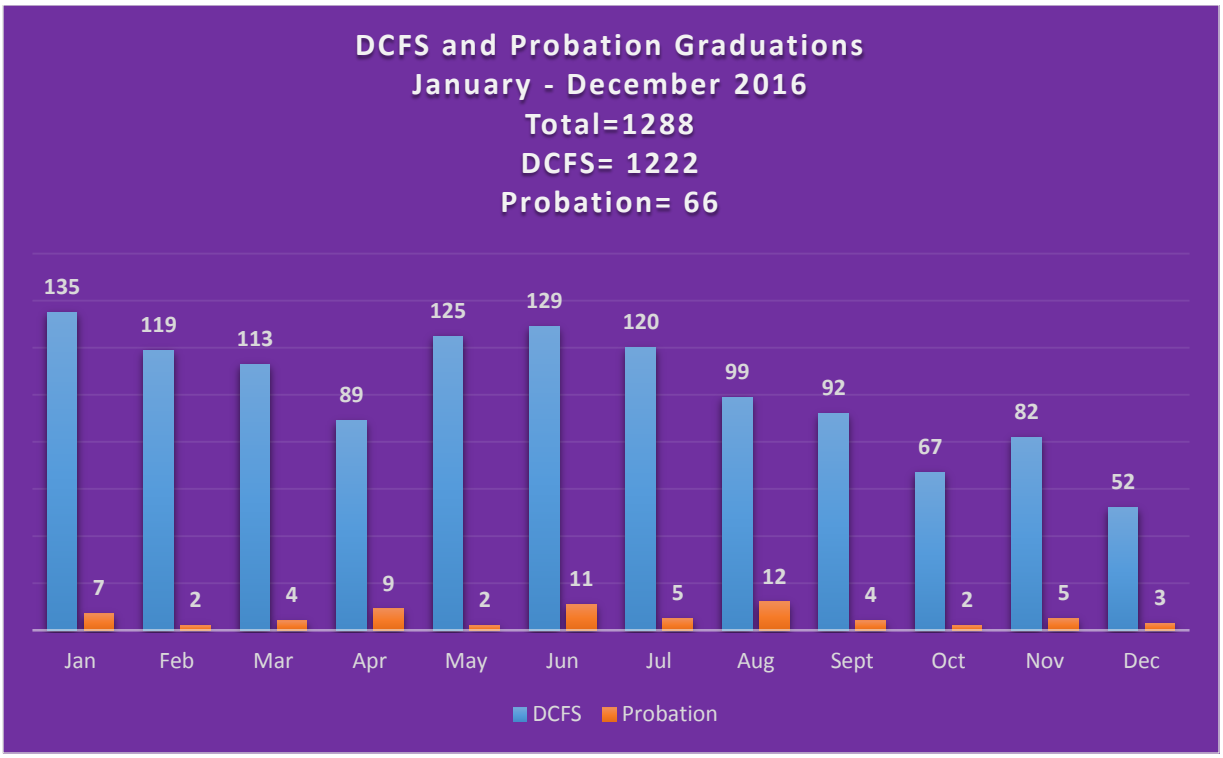
Wraparound terminations from both DCFS and the Department of Probation totaled 2,591:

- Graduations for both departments totaled 1,288
- Terminations for both departments totaled 1,303 (Please note graphs below for various termination reasons)

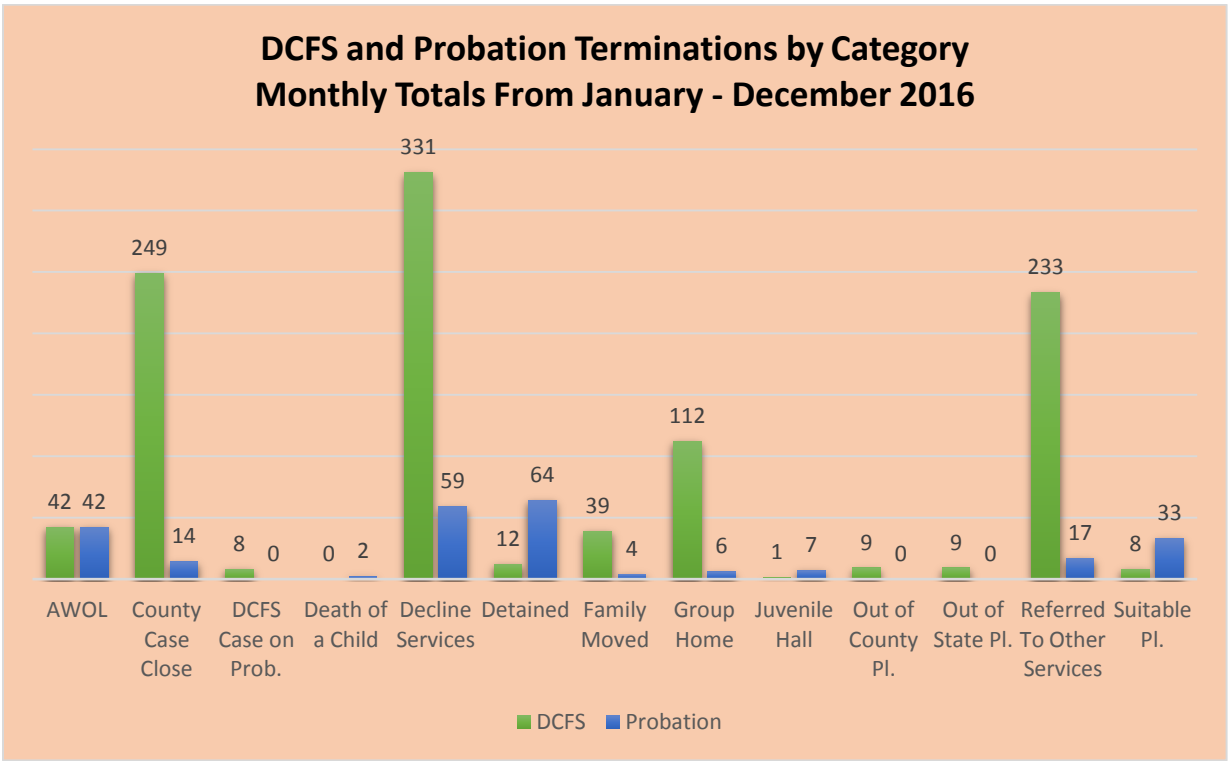


Data Source-DCFS Wraparound System -2/27/2017

Wraparound Graduations & Terminations:



Data Source-DCFS Wraparound System -2/27/2017



Data Source-DCFS Wraparound System -2/27/2017

The Panel asked, "How can a 50% termination rate be explained and how can graduation be increased?" The County response is as follows.

The programmatically-defined Wraparound "non-graduation" is due to a variety of reasons documented within the bar graph further below. Wraparound non-graduations historically occur primarily for two reasons: 1) the family refuses to engage in or sees no benefit in continuing services (30% of non-graduations) and 2) a child is prematurely discharged from Wraparound due to County case closure (20% of non-graduations).

The first reason is very likely attributable to a lack of success of the Wraparound engagement process for that family. Wraparound graduations are based on children and families meeting the goals they established with the agencies Child and Family Team as part of the development of the Plans of Care. Child and family voice and choice, a basic Wraparound principle, is instrumental in developing these goals. A family's decision to decline continued wraparound services prior to graduating the program strongly suggests the County's need to take a closer look at the criteria and manner in which we are establishing the goals to assure that we are staying child-centered rather than professionally-driven; and developing child and family plans that list the child's needs, particularly trauma and or developmental needs; and then crafting corresponding services and supports to meet the child's needs, including supports for parents and caregivers in meeting the child's needs. Moving forward, we do want to explore this with the agencies in hopes that training, oversight, and ongoing and candid discussions will ultimately improve how all families experience the wraparound program.

However, the second reason for a Wraparound "non-graduation," while unfortunate because the wraparound therapeutic process was prematurely aborted, might be viewed differently than the above. Assuming that the County case closure was not due to a child aging out without permanency, one might assume that termination of County jurisdiction means that the family must have, at the very least, made some progress with respect to safety and stabilization, indicating the likelihood that the family would have ultimately graduated from Wraparound and maintained the safety and permanency goals established by the Child and Family Team. In the past, we reviewed a sample of these types of "neutral dis-enrollment" cases and found a very low number that re-entered the system.

An interesting approach to reframing Wraparound statistics would be a departure from the programmatic definition of a Wraparound non-graduation. If we added an additional category entitled "neutral dis-enrollments," by subtracting out, from the overall universe of Wraparound discharges, those cases in which a child is prematurely discharged from Wraparound due to County case closure (20% of non-graduations); and families who moved to another area (3% of non-graduations), it yields a significantly different picture, as follows:

- Graduations: 50%
- Neutral Dis-enrollments: 23%
- Non-Graduations: 27%

Family declining Wraparound services is the highest contributor to the termination rate. DMH will be closely monitoring and requiring the Wraparound Providers to consult with the DMH liaisons prior to any case being closed due to graduation or disenrollment. This allows for the DMH liaison to review the case and problem-solve with the provider ways to increase engagement, utilize the parent partner, or if needed, transfer the case to another provider. DMH is also requiring the Wraparound Providers to follow the cases outside of their service area for continuity of care; this is hopefully decreasing the high termination rate to Wraparound Services.

Placement of Children and Youth in Group Homes and Residential Facilities

The following table shows the monthly group home census, by age range and purpose of placement for 2016. The County reports than the average census was 883 children for that period. Additional data reflects:

- An average of 88 children per month age 12 and under placed for therapeutic stabilization, which includes crisis intervention, clinical evaluation and the identification of a treatment plan
- An average of 40 children per month age 12 and under placed for emergency shelter purposes
- An average of 681 children per month age 13-17 ½ placed for therapeutic stabilization
- An average of 83 children per month age 13-17 ½ for placed for emergency shelter purposes
- An average of 115 non-minor dependents (age 18+) per month placed for therapeutic stabilization

The Panel asked for a five year comparison. A two year comparison follows.

CY 2015

The County reports that the average census was 953 children for calendar year 2015. Additional data reflects:

- An average of 65 children per month age 12 and under placed for therapeutic stabilization, which includes crisis intervention, clinical evaluation and the identification of a treatment plan
- An average of 45 children per month age 12 and under placed for emergency shelter purposes
- An average of 766 children per month age 13 – 17 ½ placed for therapeutic stabilization
- An average of 53 children per month age 13 – 17 ½ placed for emergency shelter purposes
- An average of 124 non-minor dependents (age 18+) placed for therapeutic stabilization

CY 2014

The County reports that the average census was 1104 children for calendar year 2014. Additional data reflects:

- An average of 67 children per month age 12 and under placed for therapeutic stabilization, which includes crisis intervention, clinical evaluation and the identification of a treatment plan
- An average of 31 children per month age 12 and under placed for emergency shelter purposes
- An average of 722 children per month age 13 – 17 ½ placed for therapeutic stabilization
- An average of 109 children per month age 13 – 17 ½ placed for emergency shelter purposes
- An average of 123 non-minor dependents (age 18+) placed for therapeutic stabilization

Monthly Group Home Census
(Excluding Adoptive, Guardian Home, and Non-Foster Care Placement)
January 2016 to December 2016

GH/Age	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016
0 – 12	84	109	114	109	106	86	74	76	74	80	71	68
13 – 17	691	700	689	712	696	721	680	661	660	646	650	663
18 plus	114	111	122	129	130	119	117	115	107	103	102	105
Total	**889**	**920**	**925**	**950**	**932**	**926**	**871**	**852**	**841**	**829**	**823**	**836**
ESC/Age												
0 – 12	29	24	26	32	36	51	43	39	48	55	48	55
13 – 17	72	69	60	60	73	72	82	85	103	109	109	101
18 plus	6	7	9	10	8	5	6	10	12	11	10	9
Total	**107**	**100**	**95**	**102**	**117**	**128**	**131**	**134**	**163**	**175**	**167**	**156**
MCMS/AGE												
0 – 12	4	4	3	3	3	3	2	2	2	2	2	1
13 – 17	11	13	10	9	13	15	15	18	18	19	19	22
18 plus	8	8	9	8	7	7	8	7	6	4	4	5
Total	**23**	**25**	**22**	**20**	**23**	**25**	**25**	**27**	**26**	**25**	**25**	**28**
MCMS/ESC												
0 – 12	0	0	0	0	0	0	0	0	0	0	0	0
13 – 17	0	0	0	0	0	0	0	0	0	1	0	0
18 plus	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**

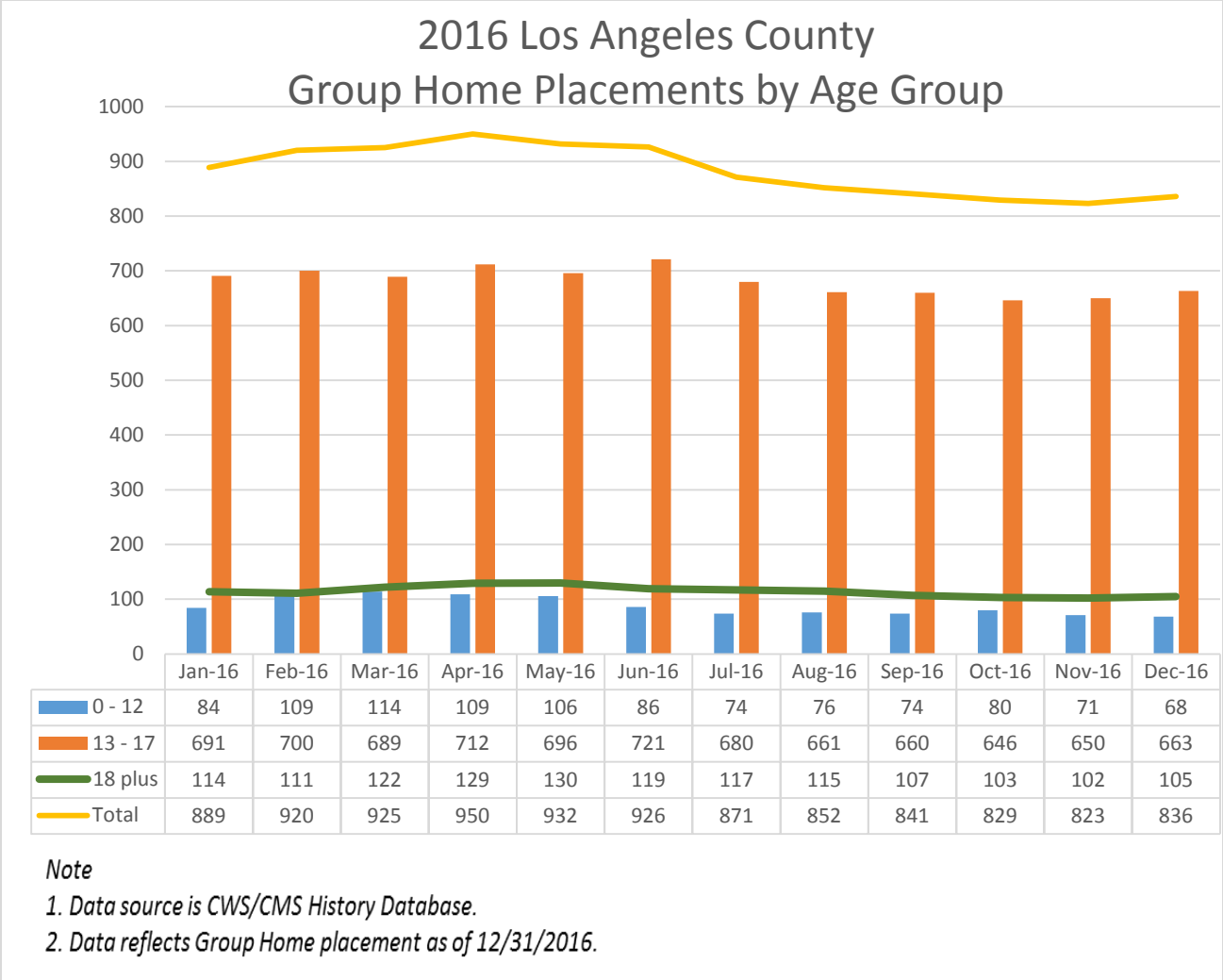
The County provided the following update:

Of the 20,726 DCFS youth reported to be in out-of-home care on December 31, 2016, 5.1% (1,055) were placed in a Group Home in order to meet their behavior needs, until a suitable alternative was identified. In addition to developing and aligning strategies and resources to support the implementation of the Continuum Care Reform (January 2017), DCFS has focused considerable effort and attention into supporting children in the least restrictive placement and reducing the number of children requiring placement in Group Homes. Some successes in this area have included providing one-to-one behavioral aide services to children in foster, relative, and home-of-parent care. Additionally, DCFS supplemented the foster care rate with additional dollars to better support children with high needs and their caregivers. The County continues to struggle with a lack of foster homes willing and able to care for children with intensive mental, developmental, and medical challenges.

The Panel asked, "Do you know how many of these newly placed children received IHBS? Is the number and percent of newly placed children declining from past years?" The County response follows.

(DMH)
A review of MAT referrals from January to June 2017, show that approximately 5-6% of newly detained youth were referred to an intensive mental health program (Wrap, IFCCS, FSP).

(DCFS)
Regarding the number and percentage of newly placed children, the only data immediately available is for the last six (6) months of Calendar Year 2016. The data indicates that 3,195 children were removed, and the average rate of detention/removal was 5.3% for that six month period. A formal service request has been submitted for the topic, and can be more thoroughly evaluated on future panel reports.



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
0 - 12	84	109	114	109	106	86	74	76	74	80	71	68
13 - 17	691	700	689	712	696	721	680	661	660	646	650	663
18 plus	114	111	122	129	130	119	117	115	107	103	102	105
Total	889	920	925	950	932	926	871	852	841	829	823	836

Note

1. Data source is CWS/CMS History Database.

2. Data reflects Group Home placement as of 12/31/2016.

Length of Stay in a Group Home Setting:

The following chart depicts the average length of placement in a congregate care setting by age group. The first (gray) column for each time period shows the percentage of all children who have been placed for that length of time. The second (blue) column represents the percentage of children within a given age group who have been placed for that length of time.

Time in Placement	0 - 2 Months		2 - 6 Months		6 - 12 Months		Over 12 Months	
Age Group	% of all Children	% of all Age Group Children	% of all children	% of all Age Group Children	% of all Children	% of all Age Group Children	% of all Children	% of all Age Group Children
0-12	13.93%	37.87%	8.06%	22.36%	8.81%	18.93%	8.55%	20.84%
13-17	81.04%	28.35%	83.54%	29.83%	78.53%	21.72%	64.14%	20.10%
18 Plus	5.04%	10.48%	8.40%	17.83%	13%	20.82%	27%	50.87%

(This is the first year data was collected)

The data reveals the following points:

- A majority of children in congregate care at any given time were between the ages of 13 and 17 years old; 28% of these children exited within 2 months, 58% exited with 6 months, and 80 % exited within 12 months of placement in a Group Home.
- The smallest population of children in a group home were between the ages of 0-12 years old; 38% of these children exited the Group Home within 2 months, 60% exited within 6 months, and 80% exited within 12 months.
- For the young adults, ages 18 years and older, 10% exited the group home within 2 months, 50% exited within 12 months and the remaining 50% remained in congregate care beyond 12 months.

OFFICE	CASELOAD (Average Referrals/Cases)							
	ER	CS						DI
	ER	ST	GN	GT	FF	PP	**Total**	DI
Belvedere	16.1	21.0	20.6	17.0			20.2	8.3
Compton	17.6	18.3	19.4	19.1			19.2	10.2
El Monte	12.2	13.0	16.3	15.0			16.1	9.2
Glendora	14.5	23.5	21.7	20.3	23.0		21.9	7.7
Lancaster	18.7	18.9	15.7	14.1			15.2	6.3
Metro North	12.9	20.8	23.9	20.0			23.0	9.8
Palmdale	12.1	22.8	20.8	19.5		32.0	20.3	9.3
Pasadena	14.8	23.3	26.1				25.9	9.9
Pomona	21.1	14.6	13.2		10.8	7.3	12.6	7.0
Santa Fe Springs	14.5	20.0	20.4		21.5		20.4	7.5
Santa Clarita	14.3	21.6	21.0	17.0			20.9	11.8
South County	14.6	12.6	22.8	15.6			21.7	10.3
Torrance	13.6	18.7	21.3	22.7	21.0		21.5	7.8
Van Nuys	11.6	17.6	20.2	18.2			19.7	10.0
Vermont Corridor	14.6	20.1	23.5	15.7			22.0	9.9
Wateridge North	9.0	23.0	25.0	15.4			23.2	8.2
Wateridge South	8.3	28.3	22.0	16.7			21.6	7.7
West L.A.	11.5	17.5	19.9				19.7	5.2
West San Fern Valley	13.4	22.3	20.6	21.2			20.7	7.6
DCFS TOTAL	**13.7**	20.1	21.0	17.5	15.7	10.4	**20.3**	**8.8**

DCFS Caseload Size

DCFS provided the following data on average caseloads.

August, 2017

1. *The report includes regional offices only*
2. *CS includes cases that are open and active on the last day of the reporting month*
3. *ER and DI include all referral and DI assignments that occurred during the whole period of the reporting month*
4. *Number of referrals are child-based count*

The above data represents <u>average</u> caseloads based on staff carrying caseloads of one or more.

To enable successful Immersion implementation County-wide, DCFS targets caseloads of:

A. 20 for Continuing Services Workers;
B. 17 for Emergency Response Workers; and
C. 10 for Dependency Investigators.

Since January 2014, DCFS has on-boarded over 2,500 newly-hired Children's Social Workers, as a result of which, as of August 30, 2017:

4. The ***<u>average</u>*** Continuing Services caseload has reduced from 31.0 to ***<u>20.3</u>***; (target: 20 cases)
5. The ***<u>average</u>*** Emergency Response Caseload has reduced from 17.4 to ***<u>13.7</u>***; (target: 17 cases) and
6. The ***<u>average</u>*** Dependency Investigations caseload has reduced from 9.9 to ***<u>8.8</u>*** (target: 10 cases).

Treatment Foster Care

Since its inception in April, 2008, the Treatment Foster Care (TFC) program has served a total of 1349 children/youth. In calendar year 2016, an average of 78 children/youth received TFC services each month, for a total of 462 children/youth served for the year. During the period of January 1, 2016 to December 31, 2016, 71 children/youth newly entered; 45 children/youth graduated; and 33 children/youth prematurely disenrolled from the TFC program. There was a net gain of four certified homes during calendar year 2016, as compared to that of the prior year. Thirty-five TFC foster parents were newly recruited; and 61 TFC foster parents left the program. As of December 31, 2016, there were a total of 79 active TFC homes; and 72 children/youth placed in those homes. As of December 31, 2016, there were 6 inactive certified homes: four homes used as respite only and two homes electing to take a break.

The Panel asked if there were any new efforts to meet the target specified in the court's order? The County's response follows.

Changes are being made with the new Intensive Services Foster Care (ISFC) contract which are intended to increase recruitment.

- DCFS has completed the SOW for the new contract which includes an increased rate.
- DCFS has had stakeholder meetings to provide more information in hopes of recruiting and contracting with additional FFAs.
- DCFS has required that program managers attend monthly roundtables to develop recruitment strategies and share success stories.
- The option of TFC (Therapeutic Foster Care) services will be made available to support the caregiver and provide more clinical oversight.

Treatment Foster Care
January – December 2016

Table 1. Number of Youth Receiving TFC Services

Month	Youth in Program at end of month	Youth Entered	Youth Graduated	Youth Disenrolled
January 2016	81	10	3	3
February 2016	82	4	1	2
March 2016	83	9	6	2
April 2016	83	4	1	5
May 2016	77	7	7	3
June 2016	79	10	5	3
July 2016	81	8	4	3
August 2016	75	3	4	6
September 2016	68	3	10	2
October 2016	73	7	3	0
November 2016	77	6	1	1
December 2016	72	0	0	3
Total	**Average of 78 per month**	**71**	**45**	**33**

Table 2. Number of TFC Foster Parents (Homes)

Month	Certified Homes at end of month	Certified FPs Gained	Certified FPs Lost
January 2016	99	3	7
February 2016	94	4	8
March 2016	92	2	5
April 2016	92	1	1
May 2016	96	7	5
June 2016	94	2	1
July 2016	96	6	5
August 2016	92	0	4
September 2016	83	2	8
October 2016	83	3	3
November 2016	78	2	12
December 2016	79	3	2
Total	**Average of 90 per month**	**35**	**61**

HUB Implementation

As previously reported, the County committed to providing a comprehensive medical examination for all newly detained children in its Strategic Plan. These assessments are completed by the Medical Hubs, located mostly in medical center settings. The County, through a partnership among the Departments of Children and Family Services and Health Services and Mental Health, continues to implement efforts to ensure that newly detained children are referred to and served by the Medical Hubs.

County Performance Update

For Calendar Year 2016, the County reports that 91.8% of newly-detained children were referred to a Medical Hub for an Initial Medical Examination (IME). In the prior reporting period, 89.3% of children had been referred. During 2016, there were 3,637 Medical Hub referrals submitted by DCFS for IMEs. The percentage of newly-detained children being referred to the Medical Hubs for the required IME continues to increase. On a regular basis, the County reviews and implements opportunities to increase the percentage of all newly-detained children being referred to the Medical Hubs to 100%. These efforts include conducting presentations at the DCFS regional offices as well as sending monthly reports to all regional offices, informing management of the current percentages of newly detained children being referred to the Medical Hubs for the IME, and to highlight the mandate to refer all newly-detained children to the Medical Hubs per DCFS policy. DCFS also meets on a quarterly basis with the Hub Medical Directors to continuously review efforts to increase the number of newly detained children who are served by the Hub. While there continues to be a high percentage of Medical Hub referrals on newly detained children submitted for the IMEs, the timeframes for the submission, based on DCFS policy, requires continued attention. Here again, the County reviews and implements opportunities to increase the timeliness of the submission of the IME referrals to the Medical Hubs. For example, in terms of reviewing the submission timelines, data reports are periodically completed to determine the timeliness rates. Further, in terms of actions taken to increase the timeliness, simple and clear e mail communications are implemented on a quarterly basis to line social workers highlighting the timeframes for submission of the referrals to the Medical Hubs.

In addition, with the County's interest for the Medical Hubs to serve the comprehensive needs of children on a continuous basis through serving as a medical home, during Calendar Year 2016, the Medical Hubs continued to provide on-going health care for children who are placed in out-of-home care. By serving as a child's medical home, the Hubs contribute to the goal of obtaining maximized health outcomes for these children who have higher needs than the non-foster care population.

During the Spring of 2016, the Department began to require that every youth admitted to Temporary Shelter Care receive a "screening" examination at the Hub. Although the purpose of the screening exam is primarily to determine if the youth has a communicable disease or condition prior to admission to a shelter, these "screening" exams have also served as an alternate means by which children with unaddressed or inadequately addressed medical issues can come to the attention of the medical Hub providers.

The County has also continued to refine the em-Hub database to increase the amount of data captured by the system and to refine the data produced by it.

IV. Qualitative Service Reviews

The County provided the following summary of its performance as measures by the Qualitative Service Review process.

DMH

System Challenges

This is the County's performance thus far from the Third Round, providing a look at the scores from the first eight Regional offices. The County's performance relative to implementation of the Core Practice Model remains modest, based on Quality Service Reviews. In analyzing QSR Practice Scores overall and comparing the baseline and the second cycle, system performance improved in the following indicators: Supports and Services and Intervention Adequacy. In Overall Practice, scores declined slightly from 51% in the Second Round to 45% in the third cycle. The most challenging practice scores so far in the Third Round include Voice and Choice and Long-Term View, scores decreased by 8% and 16%. Engagement remained stable. The most significant gains were observed in the practices of Engagement, Voice and Choice, and Long-Term View, which improved during the second cycle by 14%, 12%, and 12% respectively. Teamwork practice declined from 25% to 9% acceptable, and still continues to be the lagging indicator.

Current 2015 - 2016 performance, which reflects scores only from the Belvedere, Pomona, Compton, San Fernando Valley, Vermont Corridor, El Monte, Metro North and Glendora offices, indicates that:

- 45% of children are not making acceptable progress toward permanency
- 26% of children are considered not to have acceptable emotional well-being
- 22% of families are not making acceptable progress toward adequate functioning
- 91% of children do not have a functioning family team
- 55% of cases do not have an overall adequate assessment
- 65% of cases do not have a long-term view of child and family goals and strategies
- 32% of cases do not have plans adequate for achievement of case goals
- 50% of cases are not adequately tracked toward achievement of goals

The County began reviewing all 12 cases in the sample for each office since July in the Wateridge office. Even 12 cases represent an extremely small sample size, so reviewing only 10 or fewer, which was common, lessens confidence in the representativeness of the sample.

The Quality Improvement Office (QI), which conducts the reviews with the Department of Mental Health (DMH), remains understaffed but a new team is on the way (QI.) DMH has made consistent requests for increased staff from County authorities but have nothing certain at this report. DCFS has been implementing an organized effort to train their supervisory staff to coach caseworkers in the child and family team (CFT) process. It has prepared a cadre of "coach developers" who train supervisors as coaches and developed a growing number of front-line staff as facilitators of child and family team meetings. As the Panel has mentioned previously, the Department faces a significant barrier in that the union has been unwilling for caseworkers to make the CFT process a routine part of their work with all children and families due to caseload and workload constraints. In a June 2016 Panel meeting, the Panel met with representatives of the union, who stated that they had agreed to the DCFS policy directing the regular use of the CFT process.

DCFS

Consistent with its Strategic Plan, the County continues to conduct Qualitative Service Reviews (QSR), interview-based evaluations of the quality of frontline practice involving a sample of cases in each office. The Qualitative Service Review permits an examination of the quality of services (not just whether the service was delivered) as well as an assessment of the child's current status. Each DCFS office is reviewed on an 18-24 month cycle. QSR performance is an element of the Katie A. Settlement Agreement's exit criteria for the County.

The QSR Baseline was completed in August 2012, and the corresponding QSR Baseline Report was completed and issued in early 2013. The second QSR Review cycle was completed at the end of October 2014, with the scores finalized in December 2014. The third cycle began in February 2015; the offices that have had reviews thus far are: Belvedere, Pomona, Compton, San Fernando Valley (now Van Nuys), Vermont Corridor, El Monte, Metro North, Glendora, Lancaster, Wateridge, Santa Fe Springs, and Santa Clarita/W. San Fernando Valley. The data analysis for the third round of the following offices' QSR is pending: Lancaster, Wateridge, Santa Fe Springs, and Santa Clarita/W. San Fernando Valley. The remaining reviews are: South County (January 2017), West LA (March 2017), Pasadena (April 2017), Palmdale (June 2017), and Torrance (July 2017).

The QSR provides a basis for measuring, promoting, and strengthening the Shared Core Practice Model, and the protocol includes two domains. These are Child and Family Status Indicators, which measure how the focus child and the child's parents/caregivers are doing within the last 30 days, and Practice Indicators; which measure the core practice functions being provided with and for the focus child and the child's parents/caregivers for the most recent 90-day period. The team consists of trained DCFS and DMH reviewers who conduct a case review, and conduct interviews within a two-day period with key players in the life of the child and family's case.

The team assesses status and performance indicators to determine facts such as:

Child and Family Status:

- Is the focus child safe?
- Is the focus child stable?
- Is the focus child making progress toward permanency?
- Is the focus child making progress emotionally and behaviorally?
- Is the focus child succeeding in school?
- Is the focus child healthy?
- Are the focus child's parents making progress toward acquiring necessary parenting skills and capacity?

Practice Performance:

- Are the focus child and family meaningfully engaged and involved in case decision making, referred to as Family Voice and Choice?
- Is there a functional team made up of appropriate participants?
- Does the team understand the focus child and family's strengths and underlying needs?
- Is there a functional and individualized plan?
- Are necessary services available to implement the plan?
- Does the plan change when family circumstances change?
- Is there a stated and shared vision of the path ahead leading to safe case closure and beyond?

Overall, scores are reflective of the aggregate scores of each of the indicators for each case reviewed in the sample. Opportunities for organizational learning and practice development include providing the CSW and their supervisor face-to-face feedback on findings in the cases reviewed. In addition, oral case presentations are made in group debriefings called "Grand Rounds" and a written case story for each case reviewed is produced to provide context for the scores and to enhance learning.

The QSR scores are subject to an exit standard approved by the court. The QSR Exit Standard is stated as follows:

Each Service Planning Area is expected to individually meet passing standards for both the Child and Family Status Indicators and the System Practice Indicators (85 percent of cases with overall score of "acceptable" respectively and 70 percent "acceptable" score on Engagement, Teamwork and Assessment). Once the targets have been

reached, at the next review cycle the regional office must not score lower than 75 percent respectively on the overall Child and Family Status and System Practice Indicators, and no lower than 65 percent on a subset of System Practice indicators respectively (Engagement, Teamwork, and Assessment). The County will continue the QSR process for at least one year following exit and will post scores on a dedicated Katie A website.

Overall Score: Passing Score (Status): 85% Passing Score (Practice): 85%

The first set of three tables reflects the Status Indicators for the Third, Second and Baseline QSR Cycles. The second set of three tables reflects the Practice Indicators for the same three QSR Cycles.

The first table reflects the percentage of cases scoring within the acceptable range for Status Indicators in the Belvedere, Pomona, Compton San Fernando Valley (now Van Nuys), Vermont Corridor, El Monte, Metro North, and Glendora offices during the third cycle, followed by the overall scores combined. All scores are rounded to the nearest full percent.

QSR Third Cycle Status Indicators (2015-2017) Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrangements	Health/ Physical Well-being	Emotional Well-being	Learning & Develop.	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Belvedere	100%	100%	100%	100%	100%	89%	100%	100%	100%	60%	**100%**
Pomona	78%	67%	56%	100%	100%	67%	67%	50%	75%	57%	**67%**
Compton	89%	67%	33%	100%	89%	56%	44%	17%	83%	63%	**56%**
Van Nuys	100%	89%	44%	89%	78%	89%	78%	25%	86%	44%	**89%**
Vermont Corridor	80%	60%	50%	90%	80%	60%	70%	25%	100%	50%	**60%**
El Monte	100%	80%	50%	100%	100%	70%	80%	0%	100%	67%	**80%**
Metro North	80%	60%	50%	90%	80%	70%	90%	43%	100%	75%	**80%**
Glendora	82%	82%	55%	100%	82%	91%	91%	63%	100%	63%	**82%**
Overall	**88%**	**75%**	**56%**	**96%**	**88%**	**74%**	**78%**	**40%**	**94%**	**60%**	**77%**

QSR Second Cycle Status Indicators (2012-2013) – Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrangements	Health	Emotional Well Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Belvedere	100%	83%	92%	100%	100%	92%	75%	57%	100%	67%	**100%**
Santa Fe Springs	92%	83%	58%	100%	100%	83%	75%	50%	100%	67%	**83%**
Compton	92%	67%	67%	92%	100%	83%	67%	63%	100%	38%	**75%**
Vermont Corridor	100%	91%	82%	100%	91%	100%	64%	60%	100%	88%	**100%**
Wateridge	92%	75%	75%	83%	100%	75%	67%	38%	90%	78%	**83%**
Pomona	100%	91%	80%	100%	100%	73%	82%	86%	100%	71%	**100%**
Glendora	90%	80%	60%	90%	80%	70%	90%	50%	88%	75%	**90%**

El Monte	100%	80%	80%	100%	100%	90%	70%	100%	100%	88%	**90%**
San Fernando Valley	100%	89%	56%	100%	100%	78%	78%	40%	100%	67%	**78%**
Lancaster	100%	63%	50%	100%	100%	63%	88%	43%	100%	67%	**88%**
Metro North	89%	78%	78%	89%	89%	78%	78%	40%	100%	67%	**89%**
Pasadena	67%	89%	56%	100%	89%	67%	56%	50%	100%	67%	**78%**
Santa Clarita	78%	56%	67%	89%	78%	67%	67%	50%	86%	71%	**78%**
Torrance	90%	70%	40%	100%	100%	90%	70%	29%	100%	67%	**80%**
West LA	90%	100%	80%	100%	100%	90%	60%	57%	100%	71%	**80%**
South County	90%	90%	60%	100%	80%	90%	70%	71%	100%	75%	**90%**
Palmdale	90%	90%	40%	80%	80%	60%	60%	43%	100%	43%	**60%**
Overall	**92%**	**81%**	**66%**	**95%**	**94%**	**80%**	**71%**	**55%**	**98%**	**69%**	**85%**

QSR Baseline Status Indicators (2011-2012) - Percent Acceptable

Office	Safety Overall	Stability	Permanency	Living Arrange-ments	Health	Emotional Well Being	Learning & Development	Family Functioning	Caregiver Functioning	Family Connections	Overall Child & Family Status
Overall	**99%**	**80%**	**57%**	**95%**	**97%**	**70%**	**80%**	**61%**	**96%**	**71%**	**88%**

QSR Third Cycle Practice Indicators (2015-2017) – Percent Acceptable

Office	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Belvedere	89%	67%	0%	78%	78%	56%	78%	89%	78%	78%
Pomona	100%	78%	44%	56%	44%	67%	89%	78%	78%	78%
Compton	89%	56%	0%	33%	22%	22%	56%	33%	56%	44%
Van Nuys	44%	56%	11%	44%	22%	22%	56%	44%	44%	44%
Vermont Corridor	40%	60%	0%	40%	30%	20%	70%	50%	20%	20%
El Monte	80%	30%	10%	40%	30%	40%	70%	60%	50%	40%
Metro North	80%	40%	10%	30%	40%	30%	70%	70%	50%	50%
Glendora	64%	64%	0%	36%	18%	0%	73%	64%	27%	18%
Overall	**73%**	**56%**	**9%**	**44%**	**35%**	**31%**	**70%**	**61%**	**49%**	**45%**

QSR Second Cycle Practice Indicators (2012-2013) - Percent Acceptable

Office	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Belvedere	92%	64%	33%	58%	67%	50%	67%	55%	58%	67%
Santa Fe Springs	75%	67%	8%	50%	50%	42%	67%	58%	50%	58%
Compton	75%	67%	17%	42%	50%	50%	58%	58%	50%	58%
Vermont Corridor	55%	45%	9%	36%	55%	27%	36%	36%	27%	45%
Wateridge	58%	75%	58%	67%	67%	75%	58%	58%	50%	58%
Pomona	91%	73%	55%	45%	64%	64%	73%	55%	55%	73%
Glendora	80%	70%	40%	70%	60%	60%	70%	70%	40%	60%
El Monte	90%	70%	20%	70%	60%	50%	70%	70%	50%	60%
San Fernando Valley	89%	56%	22%	33%	44%	56%	78%	67%	78%	56%
Lancaster	88%	75%	25%	50%	50%	38%	63%	50%	50%	50%
Metro North	100%	78%	11%	44%	56%	44%	44%	22%	22%	33%
Pasadena	78%	67%	22%	33%	44%	56%	44%	44%	33%	33%
Santa Clarita	44%	67%	11%	33%	56%	44%	89%	56%	44%	44%
Torrance	50%	50%	30%	40%	20%	30%	60%	50%	30%	30%
West LA	70%	70%	20%	30%	50%	30%	60%	60%	40%	50%
South County	50%	50%	20%	40%	20%	30%	70%	60%	40%	50%
Palmdale	70%	50%	20%	30%	40%	30%	50%	30%	20%	30%
Overall	**74%**	**64%**	**25%**	**46%**	**51%**	**46%**	**62%**	**53%**	**44%**	**51%**

QSR Baseline Practice Indicators (2011-2012) – Percent Acceptable

	Engagement	Voice & Choice	Teamwork	Assessment OVERALL	Long-term View	Planning	Supports and Services	Intervention Adequacy	Tracking and Adjustment	Overall Practice
Overall	**60%**	**52%**	**18%**	**50%**	**39%**	**41%**	**66%**	**52%**	**45%**	**47%**

Analysis of QSR Findings

In analyzing the QSR Practice Scores for the first eight offices in the 3rd cycle and comparing them to the baseline, system performance improved in the following indicators: Engagement, Voice and Choice, Support and Services, Intervention Adequacy, and Tracking and Adjustment. In Overall Practice, scores decreased slightly from 47% in the baseline to 45% in the third cycle. The most significant gains were observed in the practices of Engagement and

Intervention Adequacy, which improved during the third cycle by 13% and 9% respectively. Voice and Choice, Supports and Services, and Tracking and Adjustment are each up slightly by 4%.

Teamwork practice continues to be the lagging indicator. There remains an opportunity to see an increase in this indicator as the reviews continue in all regional offices. Overall Practice has decreased slightly by 2% from baseline during the third round of reviews, from 47% to 45%. In analyzing QSR Practice Scores overall and comparing the baseline and the second cycle, system performance improved in the following indicators: Engagement, Voice & Choice, Teamwork, and Long-Term View. In Overall Practice, scores improved modestly from 47% in the baseline to 51% in the second cycle. The most significant gains were observed in the practices of Engagement, Voice & Choice, and Long-Term View, which improved during the second cycle by 14%, 12%, and 12% respectively. Although Teamwork practice improved from 18% to 25% acceptable in the second cycle, it continues to be the lagging indicator in the third cycle.

Current performance in the third cycle, after eight offices, indicates that:

- 56% of children are making acceptable progress toward permanency
- 74% of children are considered to have acceptable emotional well-being
- 40% of families are making acceptable progress toward adequate functioning
- 9% of children have a functioning family team
- 44% of cases have an overall adequate assessment
- 35% of cases have a long-term view of child and family goals and strategies
- 31% of cases have plans adequate for achievement of case goals
- 55% of cases are adequately tracked toward achievement of goals

DCFS believes that the shift from Team Decision Making (TDM) meetings to a more family-centered practice of Child and Family Team (CFT) meetings appears to have had an impact on the number and frequency of meetings occurring with children, youth and families. The lengthy certification process and learning curve required to ensure model fidelity in a county as large as Los Angeles, is likely contributing to the lower scores being seen in Teamwork during the current cycle. As practitioners learn and embed the process more deeply into practice, it is hopeful that the scores will improve as the third cycle ends and the fourth cycle begins.

V. Outcome Performance

A series of child outcomes in the areas of safety and permanency have been identified to be tracked over time to show progress. As part of this process, the parties agreed to exit targets for each indicator, meaning that the targets would have to be met as one of several conditions for ending court oversight. There is a "minimum level of performance" target and an "aspirational" target assigned to each indicator. The aspirational target is an improvement goal unrelated to exit from Court oversight. Minimum Performance Levels were set only after these data became available and essentially assured that current performance, at that time, would be a baseline below which the County does not fall. The minimal level of performance benchmarks were set during the previous national economic downturn, during which the County believed that it would be fortunate to maintain staff and resources at their current level. As a result, benchmarks at or near current levels of performance at that time were agreed to by the parties as standards. These standards are minimal and are not considered sufficiently ambitious to promote concerted action for improvement by the County.

Overview of the System Population

The table below provides data for all newly opened cases, by calendar year. The table sorts data by DCFS initial case plans of Family Maintenance (Children Remained Home) or Family

Reunification (Children Removed from Home), each of which is further sorted according to whether or not DMH services are in place. This table reflects that the number of open cases has once again dropped from 21,927 (CY 2014) to 20,011 (CY 2015). The number of cases that were provided Family Maintenance Services as the initial case plan decreased slightly over that period of time, as did the number of Family Maintenance cases receiving services from DMH.

Population of CY 2009- 2015

Calendar Year	All Children					With DMH Services					Without DMH Services				
	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total	Children Initially Remained Home	%	Children Initially Removed from Home	%	Total
2009	11,915	*57.7%*	8,747	*42.3%*	**20,662**	3,660	*41.2%*	5,216	*58.8%*	**8,876**	8,255	*70.0%*	3,531	*30.0%*	**11,786**
2010	14,061	*62.8%*	8,318	*37.2%*	**22,379**	4,867	*46.3%*	5,654	*53.7%*	**10,521**	9,194	*77.5%*	2,664	*22.5%*	**11,858**
2011	15,252	*67.1%*	7,468	*32.9%*	**22,720**	6,377	*53.4%*	5,565	*46.6%*	**11,942**	8,875	*82.3%*	1,903	*17.7%*	**10,778**
2012	14,743	*65.5%*	7,766	*34.5%*	**22,509**	6,645	*51.2%*	6,322	*48.8%*	**12,967**	8,098	*84.9%*	1,444	*15.1%*	**9,542**
2013	15,121	*64.3%*	8,406	*35.7%*	**23,527**	6,989	*50.6%*	6,828	*49.4%*	**13,817**	8,132	*83.7%*	1,578	*16.3%*	**9,710**
2014	13,992	*63.8%*	7,935	*36.2%*	**21,927**	5,376	*46.9%*	6,075	*53.1%*	**11,451**	8,616	*82.2%*	1,860	*17.8%*	**10,476**
2015	12,644	*63.2%*	7,367	*36.8%*	**20,011**	4,915	*51.7%*	4,583	*48.3%*	**9,498**	7,729	*73.5%*	2,784	*26.5%*	**10,513**

Notes:

1. Entry cohort includes children whose DCFS case started in the Calendar Year indicated.

2. Children with DMH services are those who received the DMH services between 12 months before and 12 months after the case start date.
3. Data Source is CWS/CMS DataMart as of 11/28/2016.

Safety Indicator 1.
Repeated Reports of Abuse and Neglect

This indicator tracks the degree to which children who are the subject of a substantiated referral for abuse or neglect, but are not removed from home, do not experience another substantiated report during the subsequent 12 months. The goal is to assess risk and provide supportive services effectively enough that maltreatment does not reoccur. Data shows that the County's performance on this indicator has improved from 80% of class members having no subsequent substantiated referrals within 12 months for FY 2002-2003 to 87.2% of class members having no subsequent referrals within 12 months in FY 2013-2014.

The parties agreed to a Minimum Performance Level of 82.8% and the County aspires to a goal of 83.3%. The County currently exceeds both the Minimum Performance Level goal and the aspirational goal.

Safety Indicator 1:
Percent of cases where children remained home and did not experience any new incident of substantiated referral during case open period up to 12 months.

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children initially remained home	Children without any substantiated referrals	%	Children initially remained home	Children without any substantiated referrals	%	Children initially remained home	Children without any substantiated referrals	%
2009	11,915	10,736	*90.1%*	3,660	3,093	*84.5%*	8,255	7,643	*92.6%*
2010	14,061	12,659	*90.0%*	4,867	4,150	*85.3%*	9,194	8,509	*92.5%*
2011	15,252	13,804	*90.5%*	6,377	5,520	*86.6%*	8,875	8,284	*93.3%*
2012	14,743	13,350	*90.6%*	6,645	5,838	*87.9%*	8,098	7,512	*92.8%*
2013	15,121	13,671	*90.4%*	6,989	6,103	*87.3%*	8,132	7,568	*93.1%*
2014	13,992	12,773	*91.3%*	5,376	4,701	*87.4%*	8,616	8,072	*93.7%*
2015	12,644	11,576	*91.6%*	4,915	4,385	*89.2%*	7,729	7,191	*93.0%*

Minimum Performance Level **82.8%**

Aspire to **83.3%**

Notes:

1. *Intent of indicator: Of those children who initially remained home in the Calendar Year, how many did not experience any new (First occurrence of re-abuse) substantiated referrals during the case open period, up to 12 months?*

2. The table above excludes evaluated-out referrals.

1. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.

4. Data Source is CWS/CMS DataMart as of 11/28/16.

Safety Indicator 2.
Incidence of Maltreatment by Foster Parents.

This indicator reflects the incidence of maltreatment of children by their foster parents. The incidence is small and the County's performance for class members has been consistently in the 99 percentile range, meaning that over 99% of class members in foster home settings experienced no substantiated maltreatment by their foster parents. In FY 2013-2014, 99% of all children and 99% of class members experienced no substantiated foster parent maltreatment. The indicator does not include the experience of class members in group home and residential settings due to a feature in the design of automated reporting that does not identify the specific alleged perpetrator in congregate care settings. This continues to reflect a gap in performance tracking.

The parties agreed to a Minimum Performance Level of 98.4% and the County aspires to a goal of 98.6% for this indicator. The County FY 2013-2014 performance, as measured, exceeds the Minimum Performance Level goal and the aspirational goal.

Safety Indicator 2. Of all children served in foster care in the Calendar Year, how many did not experience Maltreatment by their foster care providers?

Calendar Year	All Children			With DMH Services			Without DMH Services		
	All children served in foster care in Calendar Year	Children with no maltreatment	%	All children served in foster care in Calendar Year	Children with no maltreatment	%	All children served in foster care in Calendar Year	Children with no maltreatment	%
2009	24,700	24,379	98.7%	12,505	12,283	98.2%	12,195	12,096	99.2%
2010	23,629	23,284	98.5%	15,297	15,031	98.3%	8,332	8,253	99.1%
2011	22,667	22,393	98.8%	15,710	15,495	98.6%	6,957	6,898	99.2%
2012	22,346	22,073	98.8%	15,522	15,303	98.6%	6,824	6,770	99.2%
2013	23,930	23,702	99.0%	17,943	17,747	98.9%	5,987	5,955	99.5%
2014	22,125	21,978	99.3%	15,625	15,508	99.3%	6,500	6,470	99.5%
2015	24,563	24,319	99.0%	15,130	14,974	99.0%	9,433	9,345	99.1%

Minimum Performance Level **98.4%**

Aspire to **98.6%**

Notes:

1. The table above excludes children with abuse/neglect in group homes and guardian homes.

2. Children placed in group homes are not included in this data due to inability of correctly identify and accurately code alleged perpetrator information for these placements.

3. Children placed in guardian homes are not included because DCFS policy identifies legal guardianships as permanent placements and not as out-of-home placements.

4. The table is based on "Soundex" match of perpetrator's name and substitute care provider's name.

5. All children served in foster care includes: children already in foster care on the first day of the Calendar Year, children who initially entered foster care in the Calendar Year and children who entered foster care as a result of a FM disruption.

6. Children with DMH services are: children already in foster care on the first day of the calendar year - those who received DMH services between 12 months before and 12 months after the first day of the calendar year, children who initially entered foster care in the calendar year and children who entered foster care as a result of an FM disruption -those who received the DMH services between 12 months before and 12 months after the DCFS case start date.

7. Data Source is CWS/CMS DataMart as of 11/28/16.

DCFS provided a separate report of maltreatment of children in group homes, which is included below.

Safety Indicator 2b: Of all children placed in Group Homes in the Calendar Year, how many did not experience maltreatment by their foster care providers?

Calendar Year	All Children			With DMH Services			Without DMH Services		
	All children served in group home in calendar year	Children with no maltreatment	%	All children served in group home in calendar year	Children with no maltreatment	%	All children served in group home in calendar year	Children with no maltreatment	%
2009	3,084	3,060	99.2%	2,284	2,266	99.2%	800	794	99.3%
2010	3,133	3,119	99.6%	2,619	2,607	99.5%	514	512	99.6%
2011	3,393	3,371	99.4%	2,907	2,890	99.4%	486	481	99.0%
2012	3,407	3,383	99.3%	2,832	2,808	99.2%	575	575	100.0%
2013	3,675	3,665	99.7%	3,186	3,178	99.7%	489	487	99.6%
2014	4,253	4,247	99.9%	3,629	3,625	99.9%	624	622	99.7%
2015	3,959	3,957	99.9%	2,890	2,888	99.9%	1,069	1,069	100.0%

Notes:
1. Table includes children placed in group home during any time in the reporting period.
2. Table includes group home placement count. If children were placed in the two different group homes, it was counted twice.
3. The maltreatment is based on Non Protecting Parent Code indicator on CWS/CMS.
Data Source is CWS/CMS DataMart as of 11/28/2016.

Safety Indicator 3.
Recurrence of Maltreatment within 6 Months

This indicator measures the percentage of all children who were victims of a substantiated abuse and neglect referral who were not victims of another substantiated referral within six months. It provides some evidence of the effectiveness of efforts to prevent subsequent abuse and neglect. Class members are not identified separately in this indicator. The data shows improvement in reducing subsequent substantiated referrals between FY 2002-2003, when 90.4% of children did not experience subsequent substantiated referrals within six months, and in FY 2013-2014 when 92.6% of children did not experience a subsequent substantiated referral.

The parties agreed to a Minimum Performance Level of 92.3% and the County aspires to a goal of 92.8% for this indicator. The County FY 2013-2014 performance meets the Minimum Performance Level goal.

Minimum Performance Level **92.3%**

Aspire to **92.8%**

Calendar Year	Time Period	No Maltreatment	Total	Percent
	Jan-2009	9,440	10,187	92.7%
2009	Jul-2009	11,779	12,752	92.4%
	Jan-2010	12,345	13,555	91.1%
2010	Jul-2010	12,838	13,869	92.6%
	Jan-2011	13,693	14,694	93.2%
2011	Jul-2011	12,362	13,250	93.3%
	Jan-2012	12,977	13,919	93.2%
2012	Jul-2012	12,270	13,186	93.1%
	Jan-2013	12,786	13,755	93.0%
2013	Jul-2013	12,250	13,124	93.3%
	Jan-2014	12,145	13,078	92.9%
2014	Jul-2014	11,570	12,433	93.1%
	Jan-2015	10,923	11,797	92.6%
2015	Jul-2015	10,576	11,239	94.1%

Notes:

1. Intent of indicator: Of all children who come into contact with DCFS and were victims of a substantiated maltreatment referral during the 6-month time period, what percent were victims of another substantiated maltreatment referral within the next 6 months?
2. The table includes children who had a substantiated referral in the 6-month time period indicated.
3. The table above excludes allegations of 'at risk, sibling abused' and 'substantial risk'.
4. No maltreatment includes children who were not victims of another substantiated maltreatment referral within 6-months of the initial substantiated referral of maltreatment.
5. This is a referral based report and DMH match is not applicable
6. Data Source is CWS/CMS DataMart as of 11/28/2016.

Permanency Indicator 1.
Median Length of Stay in Out-of-Home Care

This indicator measures the median number of days that Class members are in out-of-home care, grouped by the year they entered care. The County has reduced the median length of stay for Class members from 656 days in FY 2002-2003 to 221 in FY 2012-2013.

The parties agreed to a Minimum Performance Level of 409 days and the County aspires to a goal of 383 for this indicator. The decline over time reflects a sustained improvement, and exceeds both the Minimum Performance Level and the Aspirational Performance Level.

Permanency Indicator 1. Median length of stay for children in foster care

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children initially removed from home	No. of children who exited foster care	Median Days	Children initially removed from home	No. of children who exited foster care	Median Days	Children initially removed from home	No. of children who exited foster care	Median Days
2009	8,747	3,805	283	5,216	3,456	349	3,531	349	181
2010	8,318	7,915	300	5,654	5,324	378	2,664	2,591	118
2011	7,468	6,891	301	5,565	5,065	368	1,903	1,826	110
2012	7,766	6,734	358	6,322	5,424	405	1,444	1,310	112
2013	8,406	6,340	299	6,828	5,062	322	1,578	1,278	140
2014	7,935	4,465	187	6,075	3,221	241	1,860	1,244	40
2015	7,367	3,573	153	4,583	2,144	187	2,784	1,429	108

Minimum Performance Level **409 days**

Aspire to **383 days**

Notes:

1. Intent of indicator: Of all the children who were initially placed into foster care within the calendar year, what is the median number of days that the children remained in foster care?
2. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.
3. Data Source is CWS/CMS DataMart as of 11/28/2016.

Permanency Indicator 2. Reunification within 12 Months

This indicator reflects the County's success in quickly returning children to their parents. The County continues to be challenged with its reunification achievement, although the percentage of Class children who were returned home within 12 months increased slightly from 31.7% in FY 2012-2013 to 32% in FY 2013-2014.

The parties agreed to a Minimum Performance Level of 36.4% and the County aspires to a goal of 45.6% for this indicator. The County currently does not meet the Minimum Performance Level for Class and Non-Class children.

Permanency Indicator 2. Reunification within 12 months

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children initially removed from home	Children reunified within 12 months	%	Children initially removed from home	Children reunified within 12 months	%	Children initially removed from home	Children reunified within 12 months	%
2009	8,747	3,479	*39.8%*	5,216	2057	*39.4%*	3,531	1,422	*40.3%*
2010	8,318	2,999	*36.1%*	5,654	2101	*37.2%*	2,664	898	*33.7%*
2011	7,468	2,761	*37.0%*	5,565	2085	*37.5%*	1,903	676	*35.5%*
2012	7,766	2,471	*31.8%*	6,322	1992	*31.5%*	1,444	479	*33.2%*
2013	8,406	2,659	*31.6%*	6,828	2,216	*32.5%*	1,578	443	*28.1%*
2014	7,935	2,350	*29.6%*	6,075	1,835	*30.2%*	1,860	515	*27.7%*
2015	7,367	2,116	*28.7%*	4,583	1,409	*30.7%*	2,784	707	*25.4%*

Minimum Performance Level **36.4%**

Aspire to **45.6%**

Notes:

1. Intent of indicator: How successful is DCFS at reunifying all children under its supervision quickly?

2. The table includes all children who exited foster care through reunification within 12 months of removal from home.

3. The table is based on removal date and episode end date.

4. The table includes placement episodes with 8 days or longer.

5. % equals children reunified within 12 months divided by children initially removed from home.

6. Children with DMH services are those who received the DMH services between 12 months before and 12 months after the DCFS case start date.

7. Data Source is CWS/CMS DataMart as of 11/28/2016.

Permanency Indicator 3
Adoption within 24 Months

This indicator reflects the County's success in quickly moving children to adoption who cannot return home. Data reveal a recent decrease in the percentage of Class members adopted within 24 months from 3.3% in FY 2012-2013 to 2.7% in FY 2013-2014.

The parties agreed to a Minimum Performance Level of 2% and the County aspires to a goal of 2.9% for this indicator. The County currently exceeds the Minimum Performance Level, but does not exceed the aspirational performance goal for Class members.

Permanency Indicator 3. Adoption within 24 months

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children initially removed from home	Children adopted within 24 months	%	Children initially removed from home	Children adopted within 24 months	%	Children initially removed from home	Children adopted within 24 months	%
2009	8,747	270	*3.1%*	5,216	118	*2.3%*	3,531	152	*4.3%*
2010	8,318	303	*3.6%*	5,654	172	*3.0%*	2,664	131	*4.9%*
2011	7,468	249	*3.3%*	5,565	159	*2.9%*	1,903	90	*4.7%*
2012	7,766	265	*3.4%*	6,322	183	*2.9%*	1,444	82	*5.7%*
2013	8,406	219	*2.6%*	6,828	139	*2.0%*	1,578	80	*5.1%*
2014	7,935	211	*2.7%*	6,075	48	*0.8%*	1,860	163	*8.8%*

Minimum Performance Level **2.0%**

Aspire to **2.9%**

Notes:

1. Intent of indicator: How successful is DCFS at moving children under its supervision into finalized adoption quickly?

2. The table includes all children who exited foster care through adoption within 24 months of removal from home.

3. The table is based on removal date and placement episode end date.

4. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.

5. % equals children adopted within 24 months divided by children initially removed from home.

6. Data Source is CWS/CMS DataMart as of 11/28/2016.

Permanency Indicator 4.
Reentry into Foster Care

This indicator reflects the County's success in ensuring that children returned to their parents remain in their care for at least 12 months after reunification. The data indicates that Class members re-entered foster care at a rate of 11.9% in FY 2013-2014, which represents an

improvement from FY 2012-2013, when the rate was 13.0%. Evaluating reentry rates requires sensitivity to the fact that the more intensely an agency is focused on reunification, the more likely it is that rates will be higher than systems without a reunification priority. The County has had greater success with Non-Class members, which is to be expected.

The parties agreed to a Minimum Performance Level of 13.9% and the County aspires to a goal of 12.9% for this indicator. For the FY 2012-2013, the County did meet the Minimum Performance Level as well as, the aspirational goal.

Permanency Indicator 4. Reentry into foster care during the Calendar Year and reentry within 12 months of the date of reunification

Calendar Year	All Children			With DMH Services			Without DMH Services			Minimum Performance Level **13.9%**
	Children who were reunified	Children who re-entered foster care	%	Children who were reunified	Children who re-entered foster care	%	Children who were reunified	Children who re-entered foster care	%	Aspire to **12.9%**
2009	7,193	870	*12.1%*	3,458	545	*15.8%*	3,735	325	*8.7%*	
2010	7,075	819	*11.6%*	4,357	566	*13.0%*	2,718	253	*9.3%*	
2011	6,894	890	*12.9%*	4,663	695	*14.9%*	2,231	195	*8.7%*	
2012	6,009	758	*12.6%*	4,107	593	*14.4%*	1,902	165	*8.7%*	
2013	5,927	661	*11.2%*	4,346	538	*12.4%*	1,581	123	*7.8%*	
2014	6,367	716	*11.2%*	4,598	529	*11.5%*	1,769	187	*10.6%*	
2015	5,740	691	*12.0%*	3,530	456	*12.9%*	2,210	235	*10.6%*	

Notes:

1. Intent of indicator: How successful is DCFS at ensuring children successfully remain with their parents after being reunified with parents?

2. The numerator is children who re-entered foster care within 12 months of reunification.
The denominator is children who were reunified during the calendar year. Placement episodes less than 8 days were included in accordance with the Federal Methodology.

3. Children with DMH services are those who received the DMH services between 12 months before and 12 months after the DCFS case start date.

Data source is CWS/SMS DataMart as of 11/28/2016.

Permanency Indicator 5a
Placement Stability in First Year of Placement

This indicator measures, "Of those children in foster care less than 12 months, how many remain in their first or second placement?" The County's performance continues to improve, from 74.0% of Class members having no more than two placements in their first year of care in FY 2002-2003, to 89.1% in FY 2013-2014.

The parties agreed to a Minimum Performance Level of 82.5% and the County aspires to a goal of 84.1% for this indicator. The data reflects great improvement as the performance indicators for the FY 2013-2014 far exceeds the Minimum Performance Level and the aspirational goal.

Permanency Indicator 5a. Children in foster care less than 12 months with 2 or less placements

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care less than 12 months	Children with 2 or less placements	%	Children in foster care less than 12 months	Children with 2 or less placements	%	Children in foster care less than 12 months	Children with 2 or less placements	%
2009	3,788	3,320	*87.6%*	2,218	1,891	*85.3%*	1,570	1,429	*91.0%*
2010	3,342	2,916	*87.3%*	2,271	1,931	*85.0%*	1,071	985	*92.0%*
2011	2,998	2,635	*87.9%*	2,223	1,924	*86.5%*	775	711	*91.7%*
2012	2,698	2,362	*87.5%*	2,159	1,869	*86.6%*	539	493	*91.5%*
2013	2,930	2,606	*88.9%*	2,405	2,112	*87.8%*	525	494	*94.1%*
2014	2,579	2,325	*90.2%*	1,952	1,741	*89.2%*	627	584	*93.1%*
2015	2,321	2,069	*89.1%*	1,513	1,339	*88.5%*	808	730	*90.3%*

Minimum Performance Level **82.5%**

Aspire to **84.1%**

Notes:

1. Intent of indicator: Of those children who are in foster care for less than 12 months, how many remain in their first or second placement?

2. This table includes all types of placement moves.

3. This table includes children who were in foster care for at least 8 days, but less than 12 months.

4. Children in foster care less than 12 months is determined by placement episode end date and removal date.

5. Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.

6. Data Source is CWS/CMS DataMart as of 01/28/2016.

Permanency Indicator 5b
Placement Stability in Second Year of Placement

This indicator measures children in foster care for 12 months but less than 24 months who did not experience a third or greater placement in the second year. In FY 2002-2003, 89.5% of Class members did not experience a third or greater placement, compared to 92.3% not experiencing a third or greater placement in FY 2012-2013.

The parties agreed to a Minimum Performance Level of 89.2% and the County aspires to a goal of 89.7% for this indicator. Foster home stability for class members currently exceeds Minimum Performance Level and the aspirational goal.

Permanency Indicator 5b. Children in foster care 12 months but less than 24 months, without a move to a third or greater placement(s) in the second year

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%	Children in foster care 12 months but less than 24 months	Children who did not move to a third or greater placement	%
2009	1,888	1,690	*89.5%*	1,299	1154	*88.8%*	589	536	*91.0%*
2010	1,905	1,721	*90.3%*	1,441	1302	*90.4%*	464	419	*90.3%*
2011	1,672	1,522	*91.0%*	1,362	1,243	*91.3%*	310	279	*90.0%*
2012	2,066	1,892	*91.6%*	1,815	1,669	*92.0%*	251	223	*88.8%*
2013	2,043	1,880	*92.0%*	1,727	1590	*92.1%*	316	290	*91.8%*
2014	2,273	2,051	*90.2%*	1,543	1388	*90.0%*	730	663	*90.8%*

Minimum Performance Level **89.2%**

Aspire to **89.7%**

Notes:

1. *Intent of indicator: Of those children in foster care for 12 months but less than 24 months, what percent did not move to a third or greater placement(s) in the second year?*
2. *This table includes all types of placement moves.*
3. *The denominator is children who were in foster care 12 months but less than 24 months.*
   The numerator is children who did not move to a third or greater placement in the second year.
4. *Children in foster care 12 months but less than 24 months is determined by placement episode end date and removal date.*
5. *Children with DMH services are those who received DMH services between 12 months before and 12 months after the DCFS case start date.*
6. *Data Source is CWS/CMS DataMart as of 11/28/16.*

Permanency Indicator 5c
Stability for Children in Care for More than 24 Months

This indicator is similar to 5a and 5b, except it applies to the stability of children in care more than 24 months. County performance has dropped slightly in this indicator, with 64.2% of Class members in care 24 months or more not experiencing a third or greater move in FY 2012-2013, compared with 62.6% for FY 2013-2014.

The parties agreed to a Minimum Performance Level of 58.8% and the County aspires to a goal of 61.7% for this indicator. Foster home stability for Class members currently exceeds Minimum Performance Level and the aspirational goal.

Permanency Indicator 5c. Children in foster care on the first day of the Calendar Year who have been in foster care for 24 months or more, and have not experienced a move to a third or greater placement(s) during the Calendar Year.

Calendar Year	All Children			With DMH Services			Without DMH Services		
	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%	Children in foster care for at least 24 months or more	Children who did not move to a third or greater placement	%
2009	8,342	6,598	*79.1%*	4,200	2,950	*70.2%*	4,142	3,648	*88.1%*
2010	7,292	5,731	*78.6%*	4,588	3,298	*71.9%*	2,704	2,433	*90.0%*
2011	6,570	5,187	*78.9%*	4,101	2,971	*72.4%*	2,469	2,216	*89.8%*
2012	6,312	4,894	*77.5%*	3,649	2,594	*71.1%*	2,663	2,300	*86.4%*
2013	6,394	5,033	*78.7%*	3,830	2,811	*73.4%*	2,564	2,222	*86.7%*
2014	6,640	4,632	*69.8%*	3,775	2,333	*61.8%*	2,865	2,299	*80.2%*
2015	7,102	5,655	*79.6%*	3,961	3,017	*76.2%*	3,141	2,638	*84.0%*

Minimum Performance Level **58.8%**

Aspire to **61.7%**

Notes:

1. Intent of indicator: Of those children in foster care for at least 24 months, what percent did not move to a third or greater placement(s) during the calendar year?

2. This table includes all types of placement moves.

3. The denominator is children who were in foster care on the first day of the calendar year and who have been in foster care for 24 months or more. The numerator is children who have not experienced a move to a third or greater placement(s) during the calendar year.

4. Children with DMH services are those who received DMH services between 12 months before and 12 months after the first day of each calendar year.
5. Data Source is CWS/CMS DataMart as of 11/28/2016.

VI. Panel Analysis

Training and Coaching in DCFS and DMH

During 2016, both DCFS and DMH had training and coaching agendas and both made progress in disseminating the Shared Core Practice Model. In January, 2016, DCFS and DMH leadership agreed with the Panel on the importance of consistency in strengths/needs-based practice taught in the Academy, presented in coaching and training in DCFS offices and DMH providers, in IHBS delivery, and measured in the QSR.

The implementation of the Shared Core Practice Model continues to be missing the importance of *blending* underlying needs, service crafting and teaming. These are not separate units of training or practice. Underlying needs, service crafting and teaming build on each other and work together in engagement, assessment, long-term view, emotional well-being, planning and adapting. Child and Family Team meetings (CFTs) should produce an easy-to-use, simple document that reminds everyone of strengths being built on, several specific child needs, and the

services and supports crafted to meet each child need and to provide what the caregiver requires. Underlying needs, service crafting and teaming are the foundation for permanency and IHBS.

In April 2016, for the first time the DCFS coaches and trainers met together as a group. This was an all-day training with all six of the lead DCFS coaches, 15 of the 16 DCFS trainers and five USC trainers (as well as the USC director and four DCFS managers). Panel member Marty Beyer presented an advanced underlying needs session on trauma-related needs and a service crafting session utilizing real case examples. The emphasis was on how underlying needs and service crafting could be presented in training and coaching, both in the Academy and in DCFS offices. This training was presented by Panel member Marty Beyer at both the Coaching Roundtable attended by more than 25 DCFS coaches from offices and the DMH coaches and a large supervisor training in one of the immersion offices, followed by sessions in the three other immersion offices. At the same time, Panel member Marty Beyer participated in DMH's training for new IFCCS providers and consulted on DMH's development of a training PowerPoint on underlying needs and service crafting. While considerable DMH effort was devoted to providing this training to a variety of providers, there was continuing concern by the Panel that it remained basic which DMH believed was most providers' capacity.

Meanwhile, for six months a coaching workgroup met with the leadership of a DCFS manager to develop a Strengths/Needs-Based Service Crafting PowerPoint with Panel member Marty Beyer, to be used by lead coaches, office coaches, DMH coaches and trainers. Coaches and trainers still believe Strengths/Needs-Based Service Crafting is a complex topic that staff are having continuing difficulty grasping. Strengths/Needs-Based Service Crafting (ideally a full-day training with small group practice followed by coaching in the field) was not being provided in the DCFS Academy or on any large scale in offices by early 2017.

DCFS has provided training of most staff in the four immersion offices as well as staff in other offices and new staff in the DCFS Academy including:

Shared Core Practice Model (6 hours)
Overview of the Child and Family Team-CFT (Module 1a)
Staff and family engagement prior to the CFT (Module 1b)
Facilitating the Child and Family Team-CFT (Module 2)

DMH is offering training for providers, prioritizing those serving children and families in the immersion offices, including:

Shared Core Practice Model
Intensive Care Coordination and Intensive Home-Based Mental Health Services
Underlying Needs
Family engagement prior to the CFT
Facilitating Child and Family Teams

Modules 1a, 1b and 2 were developed by a consulting team hired by DCFS and DMH. In early 2017 DCFS and DMH practice remained focused on that protocol-driven "4-Step Model" culminating in "certification" of staff in CFT facilitation. Both Departments were in the process of integrating Strengths/Needs-Based Service Crafting into practice and helping staff understand

that the CFT meeting, while important in every case, is only one aspect of the Shared Core Practice Model. Many staff had been trained to view the family telling their story as the transformative part of CFTs, with the process of reaching agreement about the child's needs (especially trauma-related needs) often not being achieved in the CFT meeting. As a result, unique supports and services to meet the specific needs of the child and support the family and caregiver in meeting the child's needs were not being designed.

The Panel encouraged DCFS and DMH to build into all training and coaching guidance for staff in how individual practice and supervision can ensure fidelity to the Shared Core Practice Model principles:

• *keep children from entering care* (by identifying children's needs and arranging intensive enough services to make sure family can meet needs)
• *placements in families, kin if possible* (by identifying children's needs and arranging intensive enough services to make sure each foster/relative home can meet those needs)
• *placements close to DCFS office* (by having sufficient foster homes and intensive services in office area)
• *first placement is only placement* (by identifying children's needs and arranging intensive enough services to make sure foster/relative home can meet those needs and if unmet needs start to undermine placement, change and intensify services).

For staff in all DCFS regional offices and DMH providers to practice according to the SCPM requires (1) identifying each child's unique needs, including trauma-related needs, in discussions with families and caregivers and in the CFT plan, the DCFS case plan, the DCFS court report and the mental health treatment plan; and (2) crafting unique services and supports to meet each child's needs, including support for parents and caregivers in meeting the child's needs, and building on child and family strengths which should be reflected in the CFT plan, the DCFS case plan, the DCFS court report and the mental health treatment plan.

It is a challenge that guiding strengths/needs-based practice relies on coaches and supervisors in DCFS regional offices and DMH providers. It is difficult to achieve sufficient consistency in the understanding of strengths/needs-based practice through just a monthly coaching roundtable and leadership provided to supervisors by ARAs, RAs and provider directors. Consequently, there is a range in the practice that is coached and supervised. The appeal of the "4-step model" was that it appears to give uniformity to practice. Unfortunately, practice focused on achieving the CFT meeting is not necessarily the strengths/needs-based service crafting required in the SCPM. The power of the family's story has produced more family-centered practice with greater voice and choice for families, which is a great achievement in DCFS and DMH. The focus on the family's story and the misinterpretation of "It is the family's CFT," however have resulted in CFT plans that often do not list specific children's needs, particularly trauma-related needs, and do not craft unique services and supports to meet each child's needs, including support for parents and caregivers in meeting the child's needs. While it is a positive step toward SCPM practice that the term "underlying needs" is frequently heard in DCFS offices and DMH providers, much of the written documentation about cases—included the CFT plan which should reflect SCPM practice—does not have specific child needs. As result, the focus remains on compliance with court-ordered services by the parent and the same generic behavior-driven services relied on in

the past for children. Improved outcomes are not likely when services and supports are not crafted to meet the unique underlying needs of the child, especially trauma-related needs.

It is essential to build on the family responsive practice of the "4-step model" by intensifying coaching and supervision in DCFS regional offices and DMH providers on strengths/needs-based service crafting. For the culture change DCFS and DMH leadership recognize is necessary, supervisors must become more confident in teaching staff to guide families and teams in reaching agreement about children's underlying needs and crafting unique services and supports to meet each child's needs, including support for parents and caregivers in meeting the child's needs. DCFS and DMH will know there is widespread practice according to the SCPM when reaching agreement about children's underlying needs and crafting unique services and supports is apparent in CFT plans, DCFS case plans, DCFS court reports and mental health treatment plans as well as examples used in training, progress reports, and QSR stories. Teaching this practice should extend to discussing child and family strengths, needs and service crafting in regular supervisory case conferences with CSWs.

Part of achieving strengths/needs-based practice is CFTs consistently occurring throughout each case, whether they are facilitated by the CSW or the mental health provider. While we are aware that practice varies, especially outside the immersion offices, when a CSW or SCSW says that a CFT occurred once many months before or that "this case doesn't require a CFT," they are not understanding that bringing together the family's team is part of practice in all cases and enhances engagement, assessment, effective services and shared long-term view.

For these strategies to be effective, the County has to address an additional, long-standing barrier to strengths/needs-based practice. It has to enable CSWs to regularly utilize CFTs for all children and families throughout the family's experience with the system. The Panel has registered concern for years that staff are not regularly conducting CFTs with families other than for the purpose of certification, meaning that relatively few families experience more than an initial CFT. The union's resistance to committing to this practice has long been the primary barrier to achieving compliance in this area, although DCFS has regularly asserted that the significant progress is occurring. The substantial increases in DCFS staff have not apparently been sufficient for the union to agree to fully support the Department's guidance. The recent DCFS manual assessment of the frequency with which families experienced multiple meetings confirmed that the incidence of multiple meetings is disappointingly low. If DCFS cannot overcome this problem, it cannot comply with the settlement terms. Renewed efforts by the County are needed to solve this problem.

Measuring Progress in Implementing Intensive Home-Based Mental Health Services

DMH has made progress in developing measures that describe important elements of the process of providing intensive home-based services. As this report reflects, DCFS can produce trend data that provide a description of indicators such as:

Number Served
Cost
Time Period
Service Type

Placement Type and Level
Service Delivery Setting

These data elements are useful in describing what services are being delivered; however they don't describe progress and results. The CICS qualitative tool may prove to be a valuable contributor to measuring results, but it has not been fully tested at this time. For the parties and the court to be provided meaningful outcome information about the effectiveness of IHBS, the County needs to expand its data collection and analysis to include new performance and outcome indicators. These indicators might include the following, some of which are already reported.

Indicators reflecting service timeliness (beyond just initial contact)
Indicators reflecting service intensity
Indicators reflecting service duration
Indicators reflecting service tailoring
Indicators reflecting placement stability
Indicators reflecting placement level
Indicators reflecting duration of restrictive placement stays
Indicators reflecting runaway incidence and duration

VII. Panel Recommendations

In its 2016 report, the Panel made six recommendations:

- Expansion of Intensive Home-Based Mental Health Services
- Expansion of Training and Coaching
- Workloads of 13 new cases ER case per month and 15 cases for continuing services workers
- Keeping children in immersion offices placed near those offices
- Focusing IFCCS on preventing placement in group care and transitioning children and youth from group care to family-based settings
- Quality Service Review enhancements, including increasing the sample size from in each office and increasing DMH resources to use the QSR to review IHBS

In our 2017 report, the Panel's recommendations reflect continuing concerns about the quality, intensity and accessibility of Intensive Home Based Services, the depth of training and coaching, placement and resource availability, and Core Practice Model implementation. The Panel's recommendations follow.

1. Ensure the Immediacy and Intensity of Intensive Home-Based Mental Health Services

The Panel has been encouraging DMH and DCFS to collaborate on data-driven improvements in the responsiveness of IHBS, especially to prevent placement in emergency shelter, group home, residential facilities and psychiatric settings and placement disruptions, including the speed of identifying the child's needs, making an IHBS referral, and IHBS beginning services, and whether services were provided as many hours a week as necessary to meet the child's needs and support both the caregiver and the parent in visits in meeting those needs.

Specifically, the County should take the following steps:

- As soon as DCFS recognizes that a child's placement may disrupt or a child is being considered for a higher level of care, an immediate referral to IHBS should be made (not delaying for lengthy triaging or committee process).

- IHBS should begin providing services immediately to address the child's needs and provide support to caregivers to prevent disruption.

- IHBS services should be designed immediately with a "whatever it takes" approach, with daily in-home services for the child and caregiver if necessary. A pre-defined team of mental health staff should not determine what services or their intensity are provided—staff assignments should be unique to the child and family, with some children receiving daily 1:1 services, some caregivers having no parent partner, some families having the assistance of parent partners in visits and sometimes trauma treatment with guidance from the child's therapist for the caregiver and family being the primary service initially.

2. Develop Additional Measures that Reflect IHBS Quality and Effectiveness

The County should develop the capacity to expand its data collection and analysis to include new performance and outcome indicators for intensive home-based mental health services. These indicators might include the following, some of which are already reported.

Indicators reflecting service timeliness (beyond just initial contact)
Indicators reflecting service intensity
Indicators reflecting service duration
Indicators reflecting service tailoring
Indicators reflecting placement stability
Indicators reflecting placement level
Indicators reflecting duration of restrictive placement stays
Indicators reflecting runaway incidence and duration

3. Strengthen Training and Coaching

For staff in all DCFS regional offices and DMH providers to practice according to the SCPM requires (1) identifying each child's unique needs, including trauma-related needs, in discussions with families and caregivers and the rest of their team; and (2) crafting unique services and supports to meet each child's needs, including support for parents and caregivers in meeting the child's needs, and building on child and family strengths. Guiding strengths/needs-based practice relies on coaches and supervisors in DCFS regional offices and DMH providers, and as a result, a range in practice is coached and supervised. For the culture change DCFS and DMH leadership recognize is necessary, supervisors must become more confident in consistent approaches to teaching staff to guide families and teams in reaching agreement about children's underlying needs and crafting unique services and supports. Agreement about children's underlying needs and crafting unique services and supports should be apparent in CFT plans, DCFS case plans, DCFS court reports and mental health treatment plans.

Caseloads in the four DCFS immersion offices are dramatically reduced, and hiring and Academy training is resulting in decreasing caseloads in all the offices. More and more DCFS staff (and DMH providers) are learning how to facilitate a CFT meeting. Now the County has to enable CSWs to regularly utilize CFT meetings for all children and families throughout the family's experience with the system. The recent DCFS report on the frequency with which families experienced multiple CFT meetings confirmed that their incidence remains disappointingly low. Most families must experience more than an initial CFT meeting. The union's resistance to committing to this practice has long been a barrier to achieving compliance in this area.

Specifically, the County should take the following steps:

- Ensure sufficient coaching and training in strengths/needs-based service crafting is provided to supervisors in DCFS and DMH that they consistently guide the staff in their units to children's include children's underlying needs and unique services and supports to meet those needs in CFT plans, DCFS case plans, DCFS court reports and mental health treatment plans.

- Ensure sufficient coaching is provided to supervisors that they consistently monitor that each family in each worker's caseload has had more than the initial CFT meeting and is having CFT meetings often enough to arrange unique services coordinated with both the parent and caregiver and together assess whether they are the right services at the right frequency.

4. Increase Placement Resource Capacity and Stability

DMH and DCFS view their commitment to prevent the trauma of disruption for children as being reflected in the steps taken to develop an Automated Community-Based Home Reservation system, interagency collaboration (that unfortunately does not include Family Foster Care Agencies) to keep children close to their families, school-based recruitment of foster parents, and designing IHBS specifically to prevent each child from having a disrupted placement. Child well-being will be enhanced if each newly placed child remains near the parent with whom

reunification is being planned and if the child does not have to change schools. This requires a major change from the past management of foster care placement, especially as the supply of homes has been shrinking.

Improving the quality of visits is a key ingredient to safe reunification. Visits are improved when there is shared parenting between parents and caregivers, with agreement between them about the child's needs and how to meet those needs, both in visits and in the caregiver's home.

DCFS offices have increased efforts to place children in family settings rather than group care, and the Panel has encouraged a new analysis of children in group care, reasons for their placement in the past year, and assessment of adequacy of mental health services for children in group care.

Specifically, the County should:

- Track any increase in placement changes within each office catchment area and identify the factors that make such placements a challenge to sustain

- Direct each immersion office to work with their FFAs to develop a plan for recruitment of additional family foster homes and place children close to home.

5. Expand the Use of the Automated Community-Based Home Reservation System.

This system informs DCFS staff where foster home vacancies in state-licensed homes exist system-wide. The County has been piloting a revision in this process for selected sites, whereby foster home vacancies in nine sites are reserved for that regional office for seven business days to permit the site to use them first. After seven days the vacancies are available system-wide. DCFS has recently implemented an improvement in which there is an automatic alert to staff when a vacancy occurs. The Panel views this innovation as promising in its ability to place children closer to their homes and communities.
However, it has significant limitations in that the majority of family foster homes are licensed by private family foster care agencies (FFAs) and these agencies are not included in this application. According to the DCFS, the following table reflects the distribution of family foster homes between state-licensed homes and FFA-licensed homes as of 2017.

State-Licensed Foster Homes			**FFA Homes**		
Available Homes	Available Beds	Placed Children	Available Homes	Available Beds	Placed Children
954	2,476	**1,838**	3,195	7,366	**4,736**
		(74.2%)			(64.2%)

For the placement system to serve all class members, the application would need to be extended to apply to FFAs as well.

The Panel recommends that DCFS formally approach FFAs about applying the process to their agencies as well.

6. Strengthen the Supervisory Role in Shared Core Practice Model Implementation

The County should develop a supervisory process that guides supervisors in mentoring CSMs and holding them accountable for performance in the CFT process, identification of underlying needs and matching services and supports to needs through service crafting. This process would likely involve case file reviews and court reports (work products) and supervisory case conferences (supervisory forums) as ways to assess performance and skill development needs, underscore accountability and teach workers SCPM skills. The development of a supervisory guide would help structure this process. Supervisors would need training/coaching themselves to fully master this element of the supervisory role. The Panel does not believe that the County can meet QSR exit standards without addressing this vital supervisory role, which is not currently being performed on an ongoing basis beyond the CFT facilitation coaching, which is quite limiting. Continuing low QSR performance in these areas provide clear evidence of the necessity of implementing such supervisory review and mentoring.

7. Complete the CFT Tracking Application

The County should complete the development of a CFT frequency tracking system that provides management data on the performance of CSWs and the percentage of youth and families that have experienced a CFT in the past three months. As part of implementing this process, the County needs to issue policy guidance outlining how staff determine if contacts with families constitute a legitimate and reportable CFT. Because functional CFTs can take varying forms, policy guidance that provides for this variability would need to be carefully crafted, probably consisting of principles. The following examples have been shared with the County by the Panel previously.

Principles of SCPM CFT Meetings

Are usually planned in advance, with participants prepared/notified in advance

Entail ongoing communication among team members before and after team meetings to ensure follow up on service plans and other actions decided by the child and family team

Always involve the family

Should include a family support or supports member chosen by the family

Should include the CSW (with some exception for weekly Wrap meetings) and at least one other team member other than the family. (Teams usually grow in size over time)

Should include the caregiver (kin or foster family)

Should include key providers such as the child's therapist and school team member, where needed

Are strength and needs-based

Identify the strengths of the child, family and caregiver

Identify the needs of the child

Are outcome focused

Specify services to meet the child's needs

Specify supports for the family (during visits) and the caregiver to meet the child's needs

Result in notes about the decisions made in the meeting provided to participants

Result in an agreed-on plan with strengths, needs and supports and services

GLOSSARY OF TERMS

ADHD – Attention deficit hyperactivity disorder

CASSP – Child and Adolescent Service System Program, a federal initiative

Child and Family Team (CFT) – A team consisting of the child and family, their informal supports, professionals and others that regularly meet face-to-face to assess, plan, coordinate, implement and adjust the services and supports provided.

Coaching - Coaching is supportive; solution focused; skillfully listening to others; sensitively asking questions; self-reflective; and strengths-needs driven.

Comprehensive Children's Services Program (CSSP) – Services and supports including a combination of intensive case management and access to several evidence-based treatment practices, including Functional Family Therapy, Trauma-Focused Cognitive Behavior Therapy and Incredible Years.

Coordinated Services Action Teams (CSAT) – A process to coordinate structure and streamline existing programs and resources to expedite mental health assessments and service linkage.

CFT – A Child and Family Team Meeting

D-Rate – Special rate for a certified foster home for children with severe emotional problems.

DCFS – Department of Children and Family Services

DMH – Department of Mental Health

EPSDT – Early Periodic Screening, Diagnosis and Treatment (a process enabling children to get Medicaid support for services, including mental health and developmental services)

ER – Emergency response

ESC – Emergency Shelter Care

FFA – Foster Family Agency (there are about 13,000 FFA beds in over 60 FFAs and about 7,000 beds in county foster homes)

FFS – Fee for Services is a network of individual clinicians who provide mental health services to individuals in the county as distinct from those directly operated and contracted agencies who provide such services.

Full Service Partnership (FSP) – An approach to mental health services that is strength-based, individualized, child and family driven, coordinated and flexible in response to child and family needs.

FGDM – Family Group Decision Making

FM – Family maintenance services, provided for families with children living in the home of either of his/her parent or LG.

Hub – Six regional sites where children will receive a comprehensive medical evaluation, mental health screening and referral for services.

IEP – Individual Education Plan

ICC - Intensive Care Coordination – ICC is similar to the activities routinely provided as Targeted Case Management (TCM); however, they must be delivered using a Child and Family Team Process to guide the planning and service delivery process. Service Components and Activities are related to the elements of the Core Practice Model.

IFCCS - Intensive Field Capable Clinical Services – phase one of the county's implementation of ICC and IHBS. Target population is youth who are in DCFS' Emergency Response Command Post, Exodus Recovery Urgent Care Center, discharging from a psychiatric hospitalization, or had a response by Field Response Operations or PMRT without a psychiatric hospitalization.

IHBS - Intensive Home-Based Mental Health Services – IHBS are intensive, individualized, and strength-based, needs-driven intervention activities that support the engagement of the child and family in the intervention strategy. IHBS are medically necessary, skill-based interventions.

MAT – Multi-Disciplinary Assessment Team

PCIT – Parent Child Interaction Therapy is an evidence base practice for ages 2 to 5 children with externalized acting out behaviors.

PTSD – Post-traumatic stress disorder

RCL – Rate Classification Level (levels of group home care, with RCL 14 being considered residential treatment; about 2,332 children are in 83 group homes

RPRT – Regional Permanency Review Teams

SCPM - Shared Core Practice Model is a practice model adopted by the Department of Children and Family Services and the Department of Mental Health to focus our work on identifying and addressing the underlying strengths and needs of children and families.

TAY – Transitional Age Youth

TFC – Treatment Foster Care – DMH will provide additional information about TFC.
Wraparound - Wraparound is a family-centered, strengths-based, and needs driven planning process for children, youth, and families that take place in a team setting